Benefits summary for HospitalCare I

Personal CHOICE®

Benefits per calendar year	You pay in-network	You pay out-of-network[1]
Deductible, individual/family	None	$5,000/$10,000
Out-of-pocket maximum, individual/family[2]	$3,000/$6,000	$10,000/$20,000
Lifetime maximum	Unlimited	Unlimited
Preventive services		
Preventive care for adults and children	$0	50%, after deductible
Mammogram		
Routine gynecological exam/Pap test (1 per calendar year)		
Pediatric immunizations		50%, no deductible
Nutrition counseling (6 visits per benefit period[3])		50%, after deductible
Physician services		
Primary care office visit[4]	$40 copayment	50%, after deductible
Specialist office visit[4]	$75 copayment	
Spinal manipulations	Not covered	Not covered
Physical/occupational therapy (20 visits per calendar year[3])	40%	50%, after deductible
Hospital/other medical services		
Inpatient hospital services/days[5]	$1,000 per admission/unlimited days	50%, after deductible/ 70 days
Emergency room (not waived if admitted)	$150	$150, no deductible
Maternity hospitalization[5]	$1,000 per admission	50%, after deductible
Outpatient surgery	$150 copayment (facility)	
Ambulance (emergency)	$0	$0, after deductible
Outpatient lab/pathology		50%, after deductible
Routine radiology/diagnostic	20%	
MRI/MRA, CT/CTA scan, PET scan[5]		
Durable medical equipment[3]	20%, up to 30 days rental per calendar year	50%, after deductible, up to 30 days rental per calendar year
Outpatient mental health care	Not covered	Not covered
Inpatient mental health care[5]	$1,000 copayment per admission[6]	50%, after deductible[6]
Substance abuse treatment		
Detox[5]	$1,000 copayment per admission[6]	50%, after deductible[6]
Rehabilitation[5]		
Outpatient	Not covered	Not covered
Prescription drug		

(continued on next page)

What's not covered?

- services not medically necessary;
- services or supplies that are experimental or investigative except routine costs associated with clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques such as in vitro fertilization, GIFT, and ZIFT;
- alternative therapies/complementary medicine;
- dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- routine foot care, unless medically necessary or associated with the treatment of diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- contraceptive devices;
- immunizations for travel or employment;
- service or supplies payable under workers' compensation, motor vehicle insurance, Medicare, or other legislation of similar purpose;
- cosmetic services/supplies;
- self-injectable drugs (except as specified under the prescription drug benefits);
- coverage for any preexisting condition, illness, or injury for which medical advice was recommended or received within the 12-month period that precedes the effective date of coverage is excluded for the first 12 months (does not apply to members under age 19);
- vision care.

[1] It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. Non-preferred providers may bill you for differences between the plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for non-preferred professional providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the provider's actual charge. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of IBC's applicable proprietary fee schedule or the provider's charges. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50 percent of the provider's charges. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability.

[2] Out-of-pocket maximum includes coinsurance and deductible. The dollar amount specified does not include any expense incurred for copays, penalties or outpatient mental/psychiatric/serious mental illness care services for Basic I and Basic II plans.

[3] Combined in- and out-of-network.

[4] Limited to 3 per year for specialist and primary care physician visits; combined in- and out-of-network.

[5] Some benefits require precertification. If you use an out-of-network provider and do not obtain a precertification, the penalty is a 50% reduction in benefit.

[6] Up to 30 days per calendar year combined in- and out-of-network for mental health and substance abuse care.

This summary represents only a partial listing of benefits and exclusions of the Personal Choice program. These managed care plans may not cover all of your health care expenses. Read your contract, member handbook, and/or benefit booklet carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (1-800-275-2583).

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