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;
- serious mental illness (Basic I and Value HSA);
- mental illness and substance abuse (Value HSA only);
- maternity (Value HSA only).

[1] It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. Out-of-network, non-participating 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 out-of-network professional providers (physicians) are based on Independence Blue Cross's (IBC) own fee schedule. 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] 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.

[3] 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.

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

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

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

[7] 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.

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 1-888-410-1119.

Independence Blue Cross

Personal Choice PPO products are underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

2010-0489 1/12

Benefits summary for Individual Personal Choice® plans

Personal CHOICE®

Individual Personal Choice® benefits at a glance

	Basic I		Basic II		Value HSA		HospitalCare I		HospitalCare II		HospitalCare III	
Benefits per calendar year	**You pay in-network**	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[2]**	**You pay in-network**	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[2]**	**You pay in-network**	**You pay out-of-network[2]**	**You pay in-network**	**You pay out-of-network[2]**
Deductible, individual/family	$500/$1,000	$5,000/$10,000	$1,000/$2,000	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000	None	$5,000/$10,000	$1,000/$2,000	$5,000/$10,000	$2,000/$4,000	$10,000/$20,000
Out-of-pocket maximum, individual/family[3]	$2,500/$5,000	$10,000/$20,000	$4,500/$9,000	$10,000/$20,000	$5,000/$10,000	$20,000/$40,000	$3,000/$6,000	$10,000/$20,000	$4,000/$8,000	$10,000/$20,000	$6,000/$12,000	$25,000/$50,000
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Preventive services												
Preventive care for adults and children	$0, no deductible	50%, no deductible	$0, no deductible	50%, no deductible	$0, no deductible	50%, no deductible	$0	50%, after deductible	$0, no deductible	50%, after deductible	$0, no deductible	50%, after deductible
Mammogram												
Routine gynecological exam/Pap test (1 per calendar year)												
Pediatric immunizations								50%, no deductible		50%, no deductible		50%, no deductible
Nutrition counseling (6 visits per benefit period[5])		50%, after deductible		50%, after deductible		50%, after deductible		50%, after deductible		50%, after deductible		50%, after deductible
Physician services												
Primary care office visit	$30 copayment, no deductible	50%, after deductible	$35 copayment, no deductible	50%, after deductible	$0, after deductible	50%, after deductible	$40 copayment[4]	50%, after deductible[4]	$40 copayment, no deductible[4]	50%, after deductible[4]	$40 copayment, no deductible[4]	50%, after deductible[4]
Specialist office visit	$50 copayment, no deductible		$60 copayment, no deductible				$75 copayment[4]	50%, after deductible[4]	$75 copayment, no deductible[4]	50%, after deductible[4]	$75 copayment, no deductible[4]	50%, after deductible[4]
Spinal manipulations (20 visits per calendar year[6])	$50 copayment, no deductible		$50 copayment, no deductible				Not covered		Not covered		Not covered	
Physical/occupational therapy (20 visits per calendar year[5])	$50 copayment, no deductible		$50 copayment, no deductible				40%	50%, after deductible	20%, after deductible	50%, after deductible	40%, after deductibe	50%, after deductible
Hospital/other medical services												
Inpatient hospital services/days[7]	20%, after deductible/ unlimited days	50%, after deductible/ 70 days	20%, after deductible/ unlimited days	50%, after deductible/ 70 days	$0, after deductible/ unlimited days	50%, after deductible/ 70 days	$1,000 per admission/ unlimited days	50%, after deductible/ 70 days	20%, after deductible/ unlimited days	50%, after deductible/ 70 days	40%, after deductible/ unlimited days	50%, after deductible/ 70 days
Emergency room (not waived if admitted)	20%, after deductible	20%, after in-network deductible	20%, after deductible	20%, after in-network deductible	$0, after deductible	$0, after in network deductible	$150	$150, no deductible	20%, after deductible	20%, after in-network deductible	40%, after deductible	40%, after in-network deductible
Maternity hospitalization[7]		50%, after deductible		50%, after deductible	not covered	not covered	$1,000 per admission	50%, after deductible		50%, after deductible		50%, after deductible
Outpatient surgery					$0, after deductible	50%, after deductible	$150 copayment (facility)					
Ambulance (emergency)	$0, after deductible	$0, after deductible		20%, after deductible		$0, after deductible	$0	$0, after deductible		20%, after deductible		40%, after deductible
Outpatient lab/pathology	20%, after deductible	50%, after deductible		50%, after deductible		50%, after deductible	20%	50%, after deductible		50%, after deductible		50%, after deductible
Routine radiology/diagnostic												
MRI/MRA, CT/CTA scan, PET scan[7]												
Durable medical equipment	20%, after deductible[7]	50%, after deductible[7]	20%, after deductible[7]	50%, after deductible[7]	$0, after deductible[7]	50%, after deductible[7]	20%, up to 30 days rental per calendar year[5]	50%, after deductible, up to 30 days rental per calendar year[5]	20%, after deductible, up to 30 days rental per calendar year[5]	50%, after deductible, up to 30 days rental per calendar year[5]	40%, after deductible, up to 30 days rental per calendar year[5]	50%, after deductible, up to 30 days rental per calendar year[5]
Outpatient mental health care[7]	20%, after deductible/30 visits per calendar year[5]	50%, after deductible/20 visits per calendar year max[5]	20%, after deductible/30 visits per calendar year[5]	50%, after deductible/20 visits per calendar year max[5]	Not covered		Not covered		Not covered		Not covered	
Inpatient mental health care[7]	20%, after deductible/30 days per calendar year[5]	50%, after deductible/20 days per calendar year max[5]	20%, after deductible/30 days per calendar year[5]	50%, after deductible/20 days per calendar year max[5]			$1,000 copayment per admission[6]	50%, after deductible[6]	20%, after deductible[6]	50%, after deductible[6]	40%, after deductible[6]	50%, after deductible[6]
Substance abuse treatment												
Detox[7]	20%, after deductible, 7 days per admission/ 4 admissions lifetime maximum[5]	50%, after deductible, 7 days per admission/ 4 admissions lifetime maximum[5]	20%, after deductible, 7 days per admission/ 4 admissions lifetime maximum[5]	50%, after deductible, 7 days per admission/ 4 admissions lifetime maximum[5]	Not covered		$1,000 copayment per admission[6]	50%, after deductible[6]	20%, after deductible[6]	50%, after deductible[6]	40%, after deductible[6]	50%, after deductible[6]
Rehabilitation[7]	20%, after deductible, 30 days per benefit period/ 90 days lifetime maximum[5]	50%, after deductible, 30 days per benefit period/ 90 days lifetime maximum[5]	20%, after deductible, 30 days per benefit period/ 90 days lifetime maximum[5]	50%, after deductible, 30 days per benefit period/ 90 days lifetime maximum[5]								
Outpatient[7]	20%, after deductible, 60 visits per year/ 120 visits lifetime maximum[5]	50%, after deductible, 60 visits per year/ 120 visits lifetime maximum[5]	20%, after deductible, 60 visits per year/ 120 visits lifetime maximum[5]	50%, after deductible, 60 visits per year/ 120 visits lifetime maximum[5]			Not covered		Not covered		Not covered	
Prescription drug	No deductible: $10 generic/ 50% brand, $250 copayment max per prescription	50%, no deductible	No deductible: $10 generic/ 50% brand, $250 copayment max per prescription	50%, no deductible	$0, after deductible	50%, after deductible						

Questions? Call us at 1-888-410-1119.