	Personal Choice 10/20/70		Personal Choice 320		Personal Choice Option 7		Personal Choice 20/30/70		HDHP HD1 HC1	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Referrals Required	No		No		No		No		No	
DEDUCTIBLE										
Individual	$0	$300	$300	$750	$0	$250	$0	$500	$1500	$5000
Family	$0	$600	$600	$1,500	$0	$500	$0	$1,000	$3000	$10000
AFTER DEDUCTIBLE, PLAN PAYS	100%	70%	90%	70%			100%	70%	100%	50%
OUT-OF-POCKET MAXIMUM										
Individual	$1,500	$2,000	$2,300	$3,000	$500	$1,000	$1,500	$3,000	$6,550	$10,000
Family	$3,000	$4,000	$4,600	$6,000	$1,000	$2,000	$3,000	$6,000	$13,100	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS										
Primary care services	$10 copayment	70%, after deductible	$20 copayment, no ded	70%, after deductible	$5 copayment	80%, after deductible	$20 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Specialist services	$20 copayment	70%, after deductible	$20 copayment, no deductible	70%, after deductible	$5 copayment	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	70%, no deductible	100%, no deductible	70%, no deductible	100%	80%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, no deductible	100% (office visit copayment does not apply)	70%, no deductible	100% (office visit copayment does not apply)	80%, no deductible	100% (office visit copayment does not apply)	70%, no deductible	100%, no deductible	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age3	100%	70%, no deductible	100%, no deductible	70%, no deductible	100%	80%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
MAMMOGRAM	100%	70%, no deductible	100%, no deductible	70%, no deductible	100%	80%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
ALLERGY INJECTIONS/TESTING (Office visit copayment waived if no office visit is charged)	100%	70%, after deductible	100%, no deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
NUTRITION COUNSELING FOR WEIGHT MGMT	100% (6 visits per year)	70%, after deductible	100% (6 visits per year)	70%, after deductible	100% (6 visits per year)	80%, after deductible	100% (6 visits per year)	70%, after deductible	100%, no deductible (6 visits per year)	50%, after deductible
MATERNITY										
First OB Visit	$10 copayment	70%, after deductible	$20 copayment, no deductible	70%, after deductible	$5 copayment	80%, after deductible	$20 copayment	80%, after deductible	100%, after deductible	50%, after deductible
Hospital	$75 per day (maximum of 5 copayments per admission)4	70%, after deductible5	90%, after deductible	70%, after deductible5	100%	80%, after deductible5	$150 per day(maximum of 5 copayments per admission)4	70%, after deductible5	100%, after deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES										
Facility	$75 per day (maximum of 5 copayments per admission)4	70%, after deductible5	90%, after deductible	70%, after deductible5	100%	80%, after deductible5	$150 per day(maximum of 5 copayments per admission)4	70%, after deductible5	100%, after deductible	50%, after deductible
Physician/ Surgeon	100%	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70 5	Unlimited	70 5	Unlimited	70 5	Unlimited	70%	100%, after deductible	50%, after deductible
OUTPATIENT SURGERY	$75 copayment - Facility 100%- Physician/Surgeon	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$150 copayment - Facility 100%- Physician/Surgeon	70%, after deductible	100%, after deductible	50%, after deductible
EMERGENCY ROOM	$40 copayment (copayment waived if admitted)		$40 copayment, no deductible (copayment waived if admitted)		$25 copayment, no deductible (copayment waived if admitted)		$40 copayment , no deductible (copayment waived if admitted)		100%, after deductible	100%, after in network deductible
AMBULANCE										
Emergency	100%	100%, no deductible	100%, after deductible	100%, after in-network deductible	100%	100%, no deductible	100%	100%, no deductible	100%, after deductible	100%, after in network deductible
Non- Emergency	100%	70% , after deductible	90%, after deductible	70% , after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
Urgent Care Center	$28 copayment	70%, after deductible	$28 copayment	70%, after deductible	$17 copayment	80%, after deductible	$28 copayment	70%, after deductible	100%, after deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible	100%, no deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY										
Routine Radiology/ Diagnostic	$20 copayments	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET SCAN	$20 copayments	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
THERAPY SERVICES										
Physical and Occupational	$15 copayment [visits 1- 30] $25[visits 31-60]	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$10 copayment	80%, after deductible	$20 copayment [visits 1- 30] $30[visits 31-60]	70%, after deductible	100%, after deductible	50%, after deductible
Speech	$15 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$10 copayment	80%, after deductible	$20 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Cardiac rehabilitation 36 Visits Per year3	$15 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$10 copayment	80%, after deductible	$20 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Pulmonary rehabilitation3	$15 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$10 copayment	80%, after deductible	$20 copayment	70%, after deductible	100%, after deductible	50%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE3	$20 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$10 copayment	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
SKILLED NURSING FACILITY	100% (120 days per year)	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	100%	70%, after deductible	100%, after deductible	50%, after deductible

	Personal Choice 10/20/70		Personal Choice 320		Personal Choice Option 7		Personal Choice 20/30/70		HDHP HD1 HC1	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	$20 copayment	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered	100%	Not covered	100%	Not Covered	100%	80%, after deductible	100%, after deductible	50%, after deductible
MENTAL HEALTH CARE										
Outpatient	$20 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$5 copayment	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Inpatient	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$150 per day(maximum of 5 copayments per admission)	70%, after deductible5	100%, after deductible	50%, after deductible
SERIOUS MENTAL ILLNESS CARE										
Outpatient	$20 copayment	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$5 copayment	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Inpatient	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$150 per day(maximum of 5 copayments per admission)	70%, after deductible	100%, after deductible	50%, after deductible
SUBSTANCE ABUSE TREATMENT										
Outpatient/Partial facility visits	$20 copayment per visit	70%, after deductible	$20 copayments, no deductible	70%, after deductible	$5 copayment	80%, after deductible	$30 copayment	70%, after deductible	100%, after deductible	50%, after deductible
Inpatient Rehabilitation	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$150 per day(maximum of 5 copayments per admission)	70%, after deductible	100%, after deductible	50%, after deductible
Inpatient Detoxification	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	90%, after deductible	70%, after deductible	100%	80%, after deductible	$150 per day(maximum of 5 copayments per admission)	70%, after deductible	100%, after deductible	50%, after deductible

1 Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the actual charge of the provider. 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 actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, payment is based on the lesser of the Independence Blue Cross (IBC) applicable proprietary fee schedule or the actualcharge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, the payment is based on 50% of the actual charge of the provider. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

2 Office visit subject to copayment

3 Combined in/out-of-network

4 Copayment waived if readmitted within 10 days of discharge for any condition.

5 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness and substance abuse services.

This benefit comparison is for illustrative purposes only. For additional information please refer to the IBC benefit booklet