

2012/2013 Personal Choice Medical Plan Comparison

COVERAGES	PERSONAL CHOICE PPO 20/30/70		PERSONAL CHOICE HDHP w/ Integrated Rx	
	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In Network</i>	<i>Out of Network</i>
Deductible - Individual/Family	\$0/\$0	\$500/\$1,000	\$1,500/\$3,000	\$5,000/\$10,000
Out of Pocket Maximum - Individual/Family	None	\$3,000/\$6,000	\$5,600/\$11,200	\$10,000/\$20,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	\$500,000
Coinsurance	100%	70%	100% after ded.	50% after ded.
Coinsurance - Individual/Family	N/A	N/A	100% after ded.	50% after ded.
Primary Care Office Visit	\$20 Copay	70% after ded.	100% after ded.	50% after ded.
Specialist Office Visit	\$30 Copay	70% after ded.	100% after ded.	50% after ded.
Maternity Care	\$20 Copay, 1st visit	70% after ded.	100% after ded.	50% after ded.
Pediatric Immunizations	100%	70% NO ded.	100% NO ded.	50% NO ded.
Routine Gyn Exam / Pap (1per year for women of any age)	100%	70% NO ded.	100%	50% NO ded.
Routine Mammogram	100%	70% NO ded.	100% NO ded.	50% NO ded.
Hospitalization	\$150 Copay/day; \$750 max/adm.	70% after ded.	100% after ded.	50% after ded.
Outpatient Radiology	\$30 Copay	70% after ded.	100% after ded.	50% after ded.
Outpatient Laboratory	100%	70% after ded.	100% after ded.	50% after ded.
Emergency Room	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	100% after ded.	Covered at in-network level
Outpatient Surgery	\$150 Copay	70% after ded.	100% after ded.	50% after ded.
Restorative Services	\$30 Copay	70% after ded.	100% after ded.	50% after ded.
	30 vists per yr.		20 visits/benefit period	
Therapy: Physical, Speech and Occupational	\$20 Copay (1-30 visits) \$30 Copay (31-60 visits)	70% after ded.	100% after ded.	50% after ded.
	60 visits total per yr. for PT/ST/OT combined		60 visits total per yr. for PT/OT combined 60 visits per yr. for ST	
Durable Medical Equipment and Prosthetics	\$30 Copay Copay/per rental period or item purchase	70% after ded.	100% after ded.	50% after ded. (\$2,500 ben. max./cal. yr.)
Prescription Drug	\$20 Generic Formulary \$40 Brand Formulary \$60 Non-Formulary	Covered 30% at a non-participating pharmacy	\$5 Generic Formulary \$20 Brand Formulary \$45 Non-Formulary	50% after ded.
Vision	Freestanding	Freestanding	Freestanding	Freestanding
Inpatient Mental Health	\$150 Copay/day \$750 max/adm.	70% after ded.	100% after ded.	50% after ded.
Outpatient Mental Health	\$30 Copay/visit	70% after ded.	100% after ded.	50% after ded.
Inpatient Serious Mental Illness	\$150 Copay/day \$750 max/adm.	70% after ded.	100% after ded.	50% after ded.
Outpatient Serious Mental Illness	\$30 Copay/day	70% after ded.	100% after ded.	50% after ded.

PLEASE NOTE: FOR SUMMARY PURPOSES ONLY. FOR FURTHER DETAILS, PLEASE REFER TO YOUR CONTRACT BOOKLET.