2012/2013 Personal Choice Medical Plan Comparison

COVERAGES	PERSONAL CHOICE PPO 20/30/70		PERSONAL CHOICE HDHP w/ Integrated Rx	
	In-Network	Out-of-Network	In Network	Out of Network
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	ავ,000/ან,000 Unlimited	Unlimited	\$500,000
Coinsurance	100%	70%	100% after ded.	50% after ded.
Coinsurance 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.
I		70% after ded.	100% after ded.	50% after ded.
Maternity Care Pediatric Immunizations	\$20 Copay, 1st visit 100%	70% after ded.	100% after ded.	50% after ded.
		70% NO ded.		50% NO ded
Routine Gyn Exam / Pap	100%	70% NO ded.	100%	50% NO ded
(1per year for women of any age)	4000/	700/ NO de d	4000/ NO ded	500/ NO ded
Routine Mammogram	100%	70% NO ded.	100% NO ded.	50% NO ded
Hospitalization	\$150 Copay/day;	70% after ded.	4000/ //	500/ 6/ 1
0	\$750 max/adm.	700/ //	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	\$150 Copay	100% after ded.	Covered at in-network level
	(waived if admitted)	(waived if admitted)	1000/	
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:	\$20 Copay (1-30 visits)	70% after ded.	100% after ded.	50% after ded.
Physical, Speech and Occupational	\$30 Copay (31-60 visits)			
			60 visits total per yr. for PT/OT combined	
	60 visits total per yr. for PT/ST/OT combined		60 visits per yr. for ST	
Durable Medical Equipment and Prosthetics	\$30 Copay	70% after ded.	100% after ded.	50% after ded.
	Copay/per rental period or			
	item purchase			(\$2,500 ben. max./cal. yr.)
Prescription Drug	\$20 Generic Formulary	Covered 30% at	\$5 Generic Formulary	50% after ded.
	\$40 Brand Formulary	a non-participating	\$20 Brand Formulary	
	\$60 Non-Formulary	pharmacy	\$45 Non-Formulary	
Vision	Freestanding	Freestanding	Freestanding	Freestanding
Inpatient Mental Health	\$150 Copay/day	70% after ded.	100% after ded.	50% after ded.
	\$750 max/adm.			
Outpatient Mental Health	\$30 Copay/visit	70% after ded.	100% after ded.	50% after ded.
Inpatient Serious Mental Illness	\$150 Copay/day	70% after ded.	100% after ded.	50% after ded.
	\$750 max/adm.			
Outpatient Serious Mental Illness	\$30 Copay/day	70% after ded.	100% after ded.	50% after ded.