2013/2014 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	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 (1 per 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 visits 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.