



	Personal Choice 10-20-70		Direct Point of Service C1-F1-01	
	In Network	Out of Network	In Network	Out of Network
DEDUCTIBLE				
Individual	\$0	\$300	\$0	\$500
Family	\$0	\$600	\$0	\$1,500
OUT-OF-POCKET MAXIMUM				
Individual	None	\$2,000	None	\$3,000
Family	None	\$4,000	None	\$9,000
LIFETIME MAXIMUM	Unlimited	\$1 Million	Unlimited	\$1 Million
DOCTOR'S OFFICE VISITS				
Primary Care Services	\$10 Copayment	70%, after deductible	\$10 Copayment	70%, after deductible
Specialist Services	\$20 Copayment	70%, after deductible	\$20 Copayment	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100% ²	70%, NO deductible	100% ²	70%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age ³	100%	70%, NO deductible	\$10 Copayment	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year ³	100%	70%, after deductible	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible	100%	70%, after deductible
MATERNITY				
First OB visit	\$10 Copayment	70%, after deductible	\$10 Copayment	70%, after deductible
Hospital	\$75 per day (Maximum of 5 Copayments per admission) ⁴	70%, after deductible	100%	70%, after deductible
INPATIENT HOSPITAL SERVICES	\$75 per day (Maximum of 5 Copayments per admission) ⁴	70%, after deductible	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	365	70	Unlimited	70
OUTPATIENT SURGERY	\$75 Copayment	70%, after deductible	100%	70%, after deductible
EMERGENCY ROOM	\$40 Copayment (Copayment waived if admitted)	\$40 Copayment, NO deductible (Copayment waived if admitted)	\$75 Copayment (Copayment waived if admitted)	\$75 Copayment (Copayment waived if admitted)
AMBULANCE	100%	70%, after deductible	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	\$20 Copayment	70%, after deductible	Needs referral from Family Doc*	
Routine Radiology/Diagnostic			\$20 Copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan			\$40 Copayment	70%, after deductible
THERAPY SERVICES				
Physical and Occupational	\$15 Copayment (visits 1-30), \$25 Copayment (visits 31-60), (60 visits per calendar year) ³	70%, after deductible (60 visits per calendar year) ³	\$20 Copayment, (30 visits per calendar year) ³ *	70%, after deductible (30 visits per calendar year) ³
Cardiac Rehabilitation	\$15 Copayment, (36 visits per calendar year) ³	70%, after deductible (36 visits per calendar year) ³	\$20 Copayment, (36 visits per calendar year) ³	70%, after deductible (36 visits per calendar year) ³
Pulmonary Rehabilitation	\$15 Copayment, (12 visits per calendar year) ³	70%, after deductible (12 visits per calendar year) ³	\$20 Copayment, (36 visits per calendar year) ³	70%, after deductible (36 visits per calendar year) ³

Speech	\$15 Copayment (visits 1-30), \$25 Copayment (visits 31-60), (60 visits per calendar year) ³	70%, after deductible (60 visits per calendar year) ³	\$20 Copayment, (20 visits per calendar year) ³	70%, after deductible (20 visits per calendar year) ³
Orthoptic/Pleoptic	\$20 Copayment, (30 visits per calendar year) ³ Limited to 8 sessions per lifetime max ³	70%, after deductible (30 visits per calendar year) ³ Limited to 8 sessions per lifetime max ³	\$20 Copayment, (8 sessions per lifetime maximum) ³	70%, after deductible, (8 sessions per lifetime maximum) ³
SPINAL MANIPULATIONS	\$20 Copayment, (30 visits per calendar year) ³	70%, after deductible (30 visits per calendar year) ³	\$20 Copayment, (20 visits per calendar year) ³	70%, after deductible (20 visits per calendar year) ³
INJECTABLE MEDICATIONS				
Standard Injectables			100%	70%, after deductible
Biotech/Specialty Injectables			\$50 Copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year ³	100%	70%, after deductible	90%	70%, after deductible
SKILLED NURSING FACILITY 120 days per calendar year ³	100%	70%, after deductible	100%	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	\$20 Copayment, (Copayment per rental period or item purchased)	70%, after deductible, (Copayment per rental period or item purchased)	100%	50%, after deductible, \$2,500 benefit maximum per calendar year
PROSTHETICS	\$20 Copayment, (Copayment per rental period or item purchased)	70%, after deductible, (Copayment per rental period or item purchased)	100%	50%, after deductible
MENTAL HEALTH CARE				
Outpatient	\$20 Copayment, (30 visits per calendar year) ³	50%, after deductible up to 20 visits per calendar year	\$20 Copayment, (20 visits per calendar year) ³	50%, after deductible (20 visits per calendar year) ³
Inpatient	\$75 per day, (30 days per calendar year) ³ (Maximum of 5 Copayments per admission) ⁴	70%, after deductible up to 20 days per calendar year	100%, 30 days per calendar year ³	70%, after deductible up to 20 days per calendar year
SERIOUS MENTAL ILLNESS CARE				
Outpatient	\$20 Copayment, (60 visits per calendar year) ³	50%, after deductible (60 visits per calendar year) ³	\$20 Copayment, (60 visits per calendar year) ³	50%, after deductible (60 visits per calendar year) ³
Inpatient	\$75 per day, (30 days per calendar year) ³ (Maximum of 5 Copayments per admission) ⁴	70%, after deductible (30 visits per calendar year) ³	100%, 30 days per calendar year ³	70%, after deductible (30 visits per calendar year) ³
SUBSTANCE ABUSE TREATMENT				
Outpatient/Partial Facility Visits	100%, (60 visits per calendar year) ³ , 120 visits lifetime maximum ³	70%, after deductible, (60 visits per calendar year) ³ , 120 visits lifetime maximum ³	\$20 Copayment, (60 visits per calendar year) ³ , 120 visits lifetime maximum ³	70%, after deductible, (60 visits per calendar year) ³ , 120 visits lifetime maximum ³
Rehabilitation	\$75 per day, (30 visits per calendar year) ³ , 90 days per lifetime maximum ³ (Maximum of 5 Copayments per admission) ⁴	70%, after deductible, (30 visits per calendar year) ³ , 90 days per lifetime maximum ³	100%, (30 days per calendar year) ³ , 90 days lifetime maximum ³	70%, after deductible, (30 days per calendar year) ³ , 90 days lifetime maximum ³

Detoxification	\$75 per day, (7 days per admission ^{3, 4} admissions lifetime maximum) ³ (Maximum of 5 copayments per admission) ⁴	70%, after deductible, (7 days per admission ^{3, 4} admissions per lifetime maximum) ³	100%, (7 days per admission ^{3, 4} admissions lifetime maximum ³)	70%, after deductible, (7 days per admission ^{3, 4} admissions lifetime maximum) ³
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1 Out-of-network, nonparticipating 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 IBC's 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 Independence Blue Cross (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. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

2 Office visit subject to copayment

3 Combined in/out-of-network

4 Copayment waived if readmitted within 90 days of discharge

* Services need referral from Primary Care Doctor (PCP). Must use PCP's Capitated Site(s).

PC 10-20-70 vs DPOS C1-F1-01 2-2009