POTTSTOWN SCHOOL DISTRICT

Independence

MEDICAL PLANS COMPARISON SHEET

	Personal Choice 10/20/70		Personal Choice C2 F2 02		Keystone Direct Point-of-Service C1 F1 01	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Referrals Required	No		No		Yes, for routine radiology/diagnostic, spinal maniputlation, and physical/occupational therapy	
DEDUCTIBLE						
Individual	$0	$300	$0	$1,500	$0	$500
Family	$0	$600	$0	$4,500	$0	$1,500
AFTER DEDUCTIBLE, PLAN PAYS	100%	70%	100%	50%	100%	70%
OUT-OF-POCKET MAXIMUM						
Individual	$1,500	$2,000	$1,500	$10,000	$1,000	$3,000
Family	$3,000	$4,000	$3,000	$30,000	$2,000	$9,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS						
Primary care services	$10 copayment	30%, after deductible	$15 copayment	50%, after deductible	$10 copayment	30%, after deductible
Specialist services	$20 copayment	30%, after deductible	$30 copayment	50%, after deductible	$20 copayment	30%, after deductible
Telemedicine (TELADOC)	No Charge	Not covered	No Charge	Not covered	No Charge	Not covered
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	30%, no deductible	100%	50%, no deductible	100%	30%, no deductible
ROUTINE EYE EXAM	N/A	N/A	N/A	N/A	N/A	N/A
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	30%, after deductible	100% (office visit copayment does not apply)	50%, no deductible	100% (office visit copayment does not apply)	30%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age	100%	30%, after deductible	100%	50%, no deductible	100%	30%, no deductible
MAMMOGRAM	100%	30%, after deductible	100%	50%, no deductible	100%	30%, no deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	No Charge	30%, after deductible	No Charge	50%, after deductible	No Charge	30%, after deductible
NUTRITION COUNSELING FOR WEIGHT MGMT	100% (6 visits per year)	30%, after deductible	100% (6 visits per year)	50%, after deductible	100% (6 visits per year)	30%, after deductible
MATERNITY						
First OB Visit	$10 copayment	30%, after deductible	$15 copayment	50%, after deductible	$10 copayment	30%, after deductible
Hospital	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	100%	30%, after deductible
INPATIENT HOSPITAL SERVICES						
Facility	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	100%	30%, after deductible
Physician/ Surgeon	100%	30%, after deductible	100%	50%, after deductible	100%	30%, after deductible
INPATIENT HOSPITAL DAYS	365 per year	70 per year	365 per year	70 per year	365 per year	70 per year
OUTPATIENT SURGERY	$75 copayment	30%, after deductible	$50 copayment	50%, after deductible	No Charge	30%, after deductible
EMERGENCY ROOM	$40 copayment (copayment waived if admitted)	Covered at INN-Network level	$100 copayment (copayment not waived if admitted)	Covered at INN-Network level	$100 copayment (copayment not waived if admitted)	Covered at INN-Network level
AMBULANCE						
Emergency	No Charge	Covered at INN-Network level	No Charge	Covered at INN-Network level	No Charge	Covered at INN-Network level
Non- Emergency	No Charge	30%, after deductible	No Charge	50%, after deductible	No Charge	30%, after deductible
URGENT CARE	$28 copayment	30%, after deductible	$70 copayment	50%, after deductible	$70 copayment	30%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	No Charge	30%, after deductible	No Charge	50%, after deductible	No Charge	30%, after deductible
OUTPATIENT RADIOLOGY						
Routine Radiology/ Diagnostic	$20 copayment	30%, after deductible	$30 copayment	50%, after deductible	$20 copayment	30%, after deductible
MRI/MRA, CT/CTA Scan, PET SCAN	$20 copayment	30%, after deductible	$60 copayment	50%, after deductible	$40 copayment	30%, after deductible

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THERAPY SERVICES						
Physical and Occupational	$15 copayment [visits 1-30] $25 copayment [visits 31-60] (60 visits per calendar year for PT/OT/ST. Combined in/out-of-network)	30%, after deductible	$30 copayment (30 total visits per calendar year for PT/OT. Combined in/out-of-network)	50%, after deductible	$20 copayment (30 total visits per calendar year for PT/OT. Combined in/out-of-network)	30%, after deductible
Speech	$15 copayment [visits 1-30] $25 copayment [visits 31-60] (60 visits per calendar year for PT/OT/ST Combined in/out-of-network)	30%, after deductible	$30 copayment (20 total visits per calendar year. Combined in/out-of-network)	50%, after deductible	$20 copayment (20 total visits per calendar year. Combined in/out-of-network)	30%, after deductible
Cardiac rehabilitation	$15 copayment (36 total visits per calendar year. Combined in/out-of-network)	30%, after deductible	$30 copayment (36 total visits per calendar year. Combined in/out-of-network)	50%, after deductible	$20 copayment (36 total visits per calendar year. Combined in/out-of-network)	30%, after deductible
Pulmonary rehabilitation	$15 copayment (12 total visits per calendar year combined in/out-of-network)	30%, after deductible	$30 copayment (36 total visits per calendar year. Combined in/out-of-network)	50%, after deductible	$20 copayment (36 total visits per calendar year. Combined in/out-of-network)	30%, after deductible
Respiratory therapy	$15 copayment	30%, after deductible	$30 copayment	50%, after deductible	$30 copayment	30%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	$20 copayment (30 visits per calendar year combined in/out-of-network)	30%, after deductible	$30 copayment (20 visits per calendar year. Combined in/out-of-network)	50%, after deductible	$20 copayment (20 visits per calendar year. Combined in/out-of-network)	30%, after deductible
CHEMO/RADIATION/DIALYSIS	No Charge	30%, after deductible	No Charge	50%, after deductible	No Charge	30%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	30%, after deductible	90%	50%, after deductible	90%	30%, after deductible
SKILLED NURSING FACILITY	No Charge (120 days per calendar year. Combined in/out-of-network)	30%, after deductible	$50 copayment per day (maximum of 5 copayments per admission) (120 days per calendar year. Combined in/out-of-network)	50%, after deductible	No Charge (120 days per calendar year)	30%, after deductible (60 days per calendar year)
HOSPICE AND HOME HEALTH CARE	No Charge	30%, after deductible	No Charge	50%, after deductible	No Charge	30%, after deductible
DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS	$20 copayment	30%, after deductible	30%	50%, after deductible	30%	50%, after deductible
OUTPATIENT DIABETIC EDUCATION	No Charge	Not covered	No Charge	Not covered	No Charge	Not covered
MENTAL HEALTH CARE						
Outpatient	$20 copayment	30%, after deductible	$30 copayment	50%, after deductible	$20 copayment	30%, after deductible
Inpatient	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	No Charge	30%, after deductible
SERIOUS MENTAL ILLNESS CARE						
Outpatient	$20 copayment	30%, after deductible	$30 copayment	50%, after deductible	$20 copayment	30%, after deductible
Inpatient	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	No Charge	30%, after deductible
SUBSTANCE ABUSE TREATMENT						
Outpatient/Partial facility	$20 copayment	30%, after deductible	$30 copayment	50%, after deductible	$20 copayment	30%, after deductible
Inpatient Rehabilitation	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	No Charge	30%, after deductible
Inpatient Detoxification	$75 copayment per day (maximum of 5 copayments per admission)	30%, after deductible	$100 copayment per day (maximum of 5 copayments per admission)	50%, after deductible	No Charge	30%, after deductible

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