School District of Philadelphia
Plan Year 2020/2021
Benefit Comparison PC320 - PC20/30/70

	Independence Blue Cross Personal Choice 320		Independence Blue Cross Personal Choice 20/30/70	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Benefits per Calendar Year				
Deductible (Embedded) - Individual / Family [1]	$300 / $900	$750 / $2,250	$0 / $0	$500 / $1,000
Out-of-Pocket Maximum (Embedded) - Individual / Family [2]	$6,350 / $12,700	N/A	$1,000 / $2,000	$3,000 / $6,000
Coinsurance	10%	30%	0%	30%
Coinsurance Limit - Individual / Family	$1,000 / $2,000	$7,000 / $14,000	N/A	N/A
Preventive Services				
Preventive Care	No Charge, no deductible	30% no deductible	No Charge	30% no deductible
Colonoscopy: Preventive Plus Providers	No Charge, no deductible	Not Covered	No Charge	Not Covered
Colonoscopy: Hospital Based	No Charge, no deductible	30% no deductible	No Charge	30% no deductible
Physician Services				
PCP Office Visit	$20 Copay, no deductible	30% after deductible	$20 Copay	30% after deductible
Specialist Visit	$30 Copay, no deductible	30% after deductible	$30 Copay	30% after deductible
Retail Health Clinic Visit	$20 Copay, no deductible	30% after deductible	$20 Copay	30% after deductible
Telemedicine	No Charge no deductible	Not Covered	No Charge	Not Covered
Urgent Care	$50 Copay, no deductible	30% after deductible	$30 Copay	30% after deductible
Therapy Services				
Physical Therapy (60 visits/year) Freestanding & Hospital Based[3]	$30 Copay, no deductible	30% after deductible	Visits 1-30: $20 Copay ; Visits 31+: No Charge	30% after deductible
Occupational Therapy (60 visits/year) Freestanding & Hospital Based [3]	$30 Copay, no deductible	30% after deductible	Visits 1-30: $20 Copay ; Visits 31+: No Charge	30% after deductible
Speech Therapy (60 visits/year)	$30 Copay, no deductible	30% after deductible	Visits 1-30: $20 Copay ; Visits 31+: No Charge	30% after deductible
Emergency Services				
Emergency Room (copay waived if admitted)	$100 Copay, no deductible	Covered at In-Network level	$40 Copay	Covered at In-Network level
Emergency Ambulance	No Charge after deductible	Covered at In-Network level	No Charge	Covered at In-Network level
Non-Emergency Ambulance	10% after deductible	30% after deductible	No Charge	30% after Deductible
Hospital Services				
Inpatient Hospital Services (IN:365 days/year; OON: 70 days/year)	10% after deductible	30% after deductible	No Charge	30% after deductible
Maternity Hospital Services [5]	10% after deductible	30% after deductible	No Charge	30% after deductible
Inpatient Professional Services (includes Maternity)	10% after deductible	30% after deductible	No Charge	30% after deductible
Outpatient Surgery				
Freestanding and Hospital Based	10% after deductible	30% after deductible	No Charge	30% after deductible
Outpatient Professional Services	10% after deductible	30% after deductible	No Charge	30% after deductible
Outpatient Diagnostics				
Diagnostic Medical (EKG)	10% after Deductible	30% after deductible	$30 Copay	30% after deductible
Routine Radiology (X-ray) Freestanding & Hospital Based	10% after Deductible	30% after deductible	$30 Copay	30% after deductible
Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan) Freestanding & Hospital Based	10% after Deductible	30% after deductible	$30 Copay	30% after deductible
Outpatient Lab & Pathology - Freestanding & Hospital Based	No Charge no deductible	30% after deductible	No Charge	30% after deductible
Other Medical Services				
Acupuncture (18 visits/year)	$30 Copay, no deductible	30% after deductible	$30 Copay	30% after deductible
Spinal Manipulations (30 visits/year) [4]	$30 Copay, no deductible	30% after deductible	$30 Copay	30% after deductible
Standard Injectables	10% after deductible	30% after deductible	No Charge [6]	30% after deductible
Allergy Injections	No Charge no deductible	30% after deductible	No Charge	30% after deductible
Biotech/Specialty Injectables	10% after deductible	30% after deductible	No Charge	30% after deductible
Chemotherapy	10% after deductible	30% after deductible	No Charge	30% after deductible
Dialysis	10% after deductible	30% after deductible	No Charge	30% after deductible
Skilled Nursing Facility	10% after deductible	30% after deductible	No Charge (140 days year)[4]	30% after deductible

	Independence Blue Cross Personal Choice 320		Independence Blue Cross Personal Choice 20/30/70	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Home Health	10% after deductible	30% after deductible	No Charge	30% after deductible
Hospice	10% after deductible	30% after deductible	No Charge	30% after deductible
Durable Medical Equipment	10% after deductible	30% after deductible	$30 Copay	30% after deductible
Mental Health Outpatient (includes serious mental illness and substance abuse)	$30 Copay, no deductible	30% after deductible	$30 Copay	30% after deductible
Mental Health Inpatient (includes serious mental illness and substance abuse) [5]	10% after deductible	30% after deductible	No Charge	30% after deductible
	Personal Choice 320		**Personal Choice 20/30/70**	
Cost	**5% Contribution Salary Less Than $60k**	**8% Contribution Salary $60k or more**	**Buy Up CASA Contribution Salary Less Than $60k**	**Buy Up CASA Contribution Salary $60k or more**
Single	$12.75	$20.39	$48.14	$55.79
Employee & Child	$17.84	$28.55	$67.40	$78.11
Employee & Children	$22.94	$36.71	$86.66	$100.43
Employee & Spouse or Life Partner	$25.49	$40.79	$96.29	$111.58
Employee & Spouse or Life Partner with Surcharge ($100 per pay)	$125.49	$140.79	$196.29	$211.58
Family	$38.24	$61.18	$144.43	$167.38
Family with Spouse or Life Partner with Surcharge ($100 per pay)	$138.24	$161.18	$244.43	$267.38

[1]Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

[2]Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

[3]Physical Therapy, Occupational Therapy, and Speech Therapy combined visit limit in and out-of-network.

[4] Combined in and out of network

[5]Inpatient Hospital out of network day limit combined for al inpatient medical, maternity, mental health, serious mental illness, and substance abuses services.

[6]PC 20/30/70 covers some Self-Administered Prescription Drugs. To obtain a list of these, logon to please logon to *https://www.ibx.com/individuals/member_resources/specialty_drug/index.html* and then click on *Self-Administered Drug List.*