

School District of Philadelphia
 April 2020
 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

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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	\$12.32	\$19.70	\$46.52	\$53.90
Employee & Child	\$17.24	\$27.59	\$65.12	\$75.47
Employee & Children	\$22.17	\$35.47	\$83.73	\$97.03
Employee & Spouse or Life Partner	\$24.63	\$39.51	\$93.04	\$107.82
Employee & Spouse or Life Partner with Surcharge (\$75 per pay)	\$99.63	\$114.41	\$168.04	\$182.82
Family	\$36.95	\$59.11	\$139.55	\$161.71
Family with Spouse or Life Partner with Surcharge (\$75 per pay)	\$111.95	\$134.11	\$214.55	\$236.71

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

²Embedded 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.

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

⁴Combined in and out of network

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

⁶PC 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*.