2023 Preferred Plan Comparison

Independence

	Keystone Point of Service 15S		Personal Choice 10/20/70%		Personal Choice 20/40/70%		Personal Choice HSA $2,000/100%	
	Referred	Self- Referred	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Referrals Required	Yes	No	No		No		No	
DEDUCTIBLE								
Individual	$0	$1,000	$0	$600	$0	$1,000	$2,000	$5,000
Family	$0	$3,000	$0	$1,200	$0	$3,000	$4,000	$10,000
AFTER DEDUCTIBLE, PLAN PAYS	100%	50%	100%	70%	100%	70%	100%	70%
OUT-OF-POCKET MAXIMUM								
Individual	$3,500	$10,000	$3,500	$7,500	$5,000	$7,500	$6,750	$10,000
Family	$7,000	$30,000	$7,000	$15,000	$10,000	$15,000	$13,500	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS								
Primary care services	$15 copayment	50%, after deductible	$10 copayment	70%, after deductible	$20 copayment	70%, after deductible	No charge after deductible	50%, after deductible
Specialist services	$25 copayment	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, (no deductible)	100%	70%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
ROUTINE EYE EXAM	$25 copayment (once every two calendar years)	Not covered	N/A	N/A	N/A	N/A	N/A	N/A
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	50%, no deductible	100% (office visit copayment does not apply)	70%, no deductible	100% (office visit copayment does not apply)	70%, no deductible	100%, no deductible	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age	100%	50%, no deductible	100%	70%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
MAMMOGRAM	100%	50%, no deductible	100%	70%, no deductible	100%	70%, no deductible	100%, no deductible	50%, no deductible
ALLERGY INJECTIONS/TESTING (Office visit copayment waived if no office visit is charged)	100%	50%, after deductible	100%	70% after deductible	100%	70% after deductible	No charge after deductible	50%, after deductible
NUTRITION COUNSELING FOR WEIGHT MGMT	100% (6 visits per year)	50%, after deductible	100% (6 visits per year)	70%, after deductible	100% (6 visits per year)	70%, after deductible	100%, no deductible (6 visits per year)	50%, after deductible
MATERNITY								
First OB Visit	$25 copayment	50%, after deductible	$10 Copayment	70% , after deductible	$20 Copayment	70% , after deductible	No charge after deductible	50%, after deductible
Hospital	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70% , after deductible	$350 copayment per admission	70% , after deductible	No charge after deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES								
Facility	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70% , after deductible	$350 copayment per admission	70% , after deductible	No charge after deductible	50%, after deductible
Physician/ Surgeon	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70	Unlimited	70	Unlimited	70	Unlimited	70
OUTPATIENT SURGERY	$100 Copayment (facility)	50%, after deductible	$75 Copay	70%, after deductible	$200 Copayment	70%, after deductible	No charge after deductible	50%, after deductible
EMERGENCY ROOM	$100 copayment (copayment waived if admitted)	$100 copayment, no deductible (copayment waived if admitted)	$100 copayment (copayment waived if admitted)	$100 copayment, no deductible (copayment waived if admitted)	$100 copayment (copayment waived if admitted)	$100 copayment, no deductible (copayment waived if admitted)	No charge after deductible	50%, after deductible

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AMBULANCE								
Emergency	100%	100%	100%	100%, no deductible	100%	100%, no deductible	No charge after deductible	50%, after deductible
Non- Emergency	100%	50% , after deductible	100%	70% , after deductible	100%	70% , after deductible	No charge after deductible	50%, after deductible
URGENT CARE	$24 copayment	50%, after deductible	$28 copayment	70% after deductible	$28 copayment	70% after deductible	No charge after deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
OUTPATIENT RADIOLOGY								
Routine Radiology/ Diagnostic	100%	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET SCAN	100%	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
THERAPY SERVICES								
Physical, Speech, and Occupational	100% (60 visits per year for PT, ST, OT))	50%, after deductible	$15 copayment [visits 1-30] $25 copayment [visits 31-60] (60 visits per calendar year for PT/ST/OT)	70%, after deductible	$20 copayment [visits 1-30] $40 copayment [visits 31-60] (60 visits per calendar year for PT/ST/OT)	70%, after deductible	No charge after deductible (30 visits per year)	50%, after deductible
Cardiac rehabilitation	100% (60 visits per year)	50%, after deductible	100% (36 visits per year)	70%, after deductible	100% (36 visits per year)	70%, after deductible	No charge after deductible (36 visits per year)	50%, after deductible
Pulmonary rehabilitation	100% (60 visits per year)	50%, after deductible	100% (36 visits per year)	70%, after deductible	100% (36 visits per year)	70%, after deductible	No charge after deductible (36 visits per year)	50%, after deductible
Respiratory therapy	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible (36 visits per year)	50%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	100% (100 visits per calendar year)	50%, after deductible	$20 copayment (30 visits per calendar year)	70%, after deductible	$40 copayment (30 visits per calendar year)	70%, after deductible	No charge after deductible (20 visits per year)	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
SKILLED NURSING FACILITY	100% (up to 180 days)	50%, after deductible(up to 240 days)	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	50%, after deductible	100%	70%, after deductible	100%	70%, after deductible	No charge after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
OUTPATIENT DIABETIC EDUCATION			100%	Not covered	100%	Not covered	No charge after deductible	50%, after deductible
MENTAL HEALTH CARE								
Outpatient	$25 copayment	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
Inpatient	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	$350 copayment per admission	70%, after deductible	No charge after deductible	50%, after deductible
SERIOUS MENTAL ILLNESS CARE								
Outpatient	$25 copayment	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible
Inpatient	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	$350 copayment per admission	70%, after deductible	No charge after deductible	50%, after deductible
SUBSTANCE ABUSE TREATMENT								
Outpatient/Partial facility visits	$25 copayment	50%, after deductible	$20 copayment	70%, after deductible	$40 copayment	70%, after deductible	No charge after deductible	50%, after deductible

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Inpatient Rehabilitation	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	$350 copayment per admission	70%, after deductible	No charge after deductible	50%, after deductible
Inpatient Detoxification	$250 copayment per admission	50%, after deductible	$75 per day (maximum of 5 copayments per admission)	70%, after deductible	$350 copayment per admission	70%, after deductible	No charge after deductible	50%, after deductible

This document is for comparison purposes only. For further detail on benefit exclusions and precertification requirements, please refer to the Benefits at A Glance Summaries for each plan design.