

Independence Blue Cross Health Plans

**Personal Choice**

Benefits	Association Prime Option	
	In-Network	Out-of-Network
<b>Your Annual Deductible - Individual/Family</b> (applies to all services unless otherwise specified)	\$200/\$400	\$1000/\$2000
<b>After Deductible Plan Pays</b> (unless otherwise specified)	100%	70%
<b>Your Co-Insurance</b>	0%	30%
<b>Overall Lifetime Maximum</b>	Unlimited	\$500,000
<b>Psychiatric Lifetime Maximum</b>	\$50,000	\$50,000
<b>Annual Inpatient Hospital Days</b>	365	70
<b>Annual Inpatient Psychiatric Days</b>	30	20
<b>Office Visits</b>	(No Deductible) 100% with \$5 copay	70%
<b>Preventive Care for Adults &amp; Children</b>	(No Deductible) 100% with \$5 copay	70%
<b>Pediatric Immunizations</b>	(No Deductible) 100%	(No Deductible) 70%
<b>Annual OB/GYN Exam and Routine Mammography</b>	(No Deductible) 100%	(No Deductible) 70%
<b>Outpatient Therapies</b>		
Physical, Speech, Occupational	(No Deductible) 100% with \$15 copay	70%
Cardiac Rehabilitation (18 visits/year)	(No Deductible) 100% with \$15 copay	70%
Respiratory Therapy	(No Deductible) 100% with \$15 copay	70%

Pulmonary Rehabilitation (12 visits/year)	(No Deductible) 100% with \$15 copay	70%
Restorative Services (including spinal manipulation)	(No Deductible) 100% with \$15 copay	70%
<b>Outpatient psychiatric care*</b>	30 visits per year	
Visits 1-9	(No Deductible) 100% with \$20 copay	
Visits 10+	(No Deductible) 100% with \$30 copay	
<b>Emergency Room</b>	(No Deductible) 100% with \$40 copay <i>Copay waived if admitted</i>	(No Deductible) 100% with \$40 copay <i>Copay waived if admitted</i>
<b>Laboratory</b>	(No Deductible) 100%	70%
<b>Hospital (Inpatient &amp; Outpatient Care)</b>	100%	70%
<b>Surgery and Anesthesia</b>	100%	70%
<b>Maternity and Newborn Care</b>	100%	70%
<b>Skilled Nursing (90 Days/Person/Year)</b>	100%	70%
<b>Chemo/Radiation/Home Infusion Therapy</b>	100%	70%
<b>Hospice/Home Health</b>	100%	70%
<b>Transplant</b>	100%	70%
<b>X-Ray</b>	100%	70%
<b>Durable Medical Equipment &amp; Prosthetics</b>	100%	70%
<b>Ambulance</b>	100%	70%
<b>Blood</b>	100%	70%
<b>Alcohol/Substance*</b>		
<ul style="list-style-type: none"> <li>Inpatient - 7 days per detoxification admission (Lifetime maximum of 4 confinements)</li> </ul>	100%	70%
<ul style="list-style-type: none"> <li>Residential - 30 day confinement per benefit period (Lifetime maximum of 90 days)</li> </ul>	100%	70%
<ul style="list-style-type: none"> <li>Outpatient - 30 visits per benefit period (Lifetime maximum of 120 visits)</li> </ul>	100%	70%
<b>Outpatient Prescription Drugs</b>	Generic 80% Brand 50%**	Generic 80% Brand 50%**

\* Additional days/visits may be available; please refer to your contract for details (lifetime limits apply)

\*\*Even if there is no generic equivalent

+ Out-of-Network maximums are part of and not separate from the corresponding In-Network benefit maximums. This Product Grid is a highlight of benefits. For specific details, conditions and exclusions, please refer to your contract.

