2024 Plan Comparison

	Personal Choice PC 215		Keystone DPOS C1-F1-01		Keystone DPOS C2-F1-01	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Referrals Required	No		Yes		Yes	
DEDUCTIBLE						
Individual	$200	$500	$0	$500	$0	$500
Family	$400	$1,000	$0	$1,500	$0	$1,500
AFTER DEDUCTIBLE, PLAN PAYS	100%	80%	100%	70%	100%	70%
OUT-OF-POCKET MAXIMUM						
Individual	$1,200	$3,000	$1,000	$3,000	$1,000	$3,000
Family	$2,400	$6,000	$2,000	$9,000	$2,000	$9,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS						
Primary care services	$15 copayment, no deductible	80%, after deductible	$10 copayment	70%, after deductible	$15 copayment	70%, after deductible
Specialist services	$15 copayment, no deductible	80%, after deductible	$20 copayment	70%, after deductible	$30 copayment	70%, after deductible
TELEMEDICINE	$0 copayment	not covered	$0 copayment	not covered	$0 copayment	not covered
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, no deductible	80%, no deductible	100%	70%, no deductible	100%	70%, no deductible
ROUTINE EYE EXAM	N/A	N/A	$20 copayment (once every two years)	N/A	$30 copayment (once every two years)	N/A
PEDIATRIC IMMUNIZATIONS	100%, no deductible (office visit copayment does not apply)	80%, no deductible	100% (office visit copayment does not apply)	70%, no deductible	100% (office visit copayment does not apply)	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP	100%, no deductible	80%, no deductible	100%	70%, no deductible	100%	70%, no deductible
MAMMOGRAM	100%, no deductible	80%, no deductible	100%	70%, no deductible	100%	70%, no deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%, no deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT - 6 visits per year	100%, no deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
MATERNITY						
First OB Visit	$15 copayment, no deductible	80%, after deductible	$10 Copayment	70% , after deductible	$15 Copayment	70% , after deductible
Hospital	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
INPATIENT HOSPITAL SERVICES						
Facility	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
Physician/ Surgeon	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70	Unlimited	70	Unlimited	70
OUTPATIENT SURGERY	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
EMERGENCY ROOM	$25 copayment, no deductible (copayment waived if admitted)	$25 copayment, no deductible (copayment waived if admitted)	$75 copayment (copayment waived if admitted)	$75 copayment, no deductible (copayment waived if admitted)	$100 copayment (copayment NOT waived if admitted)	$100 copayment, no deductible (copayment NOT waived if admitted)
AMBULANCE						
Emergency	100%, after deductible	100%, after deductible	100%	100%, no deductible	100%	100%, no deductible
Non- Emergency	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
URGENT CARE	$17 copayment	80%, after deductible	$52 copayment	70%, after deductible	$70 copayment	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, no deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
OUTPATIENT RADIOLOGY						
Routine Radiology/ Diagnostic	100%, after deductible	80%, after deductible	$20 copayment	70%, after deductible	$30 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET SCAN	100%, after deductible	80%, after deductible	$40 copayment	70%, after deductible	$60 copayment	70%, after deductible

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	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
THERAPY SERVICES						
Physical and Occupational	$15 copayment, no deductible	80%, after deductible	$20 copayment (30 total visits per year for PT/OT combined)	70%, after deductible (30 total visits per year for PT/OT combined)	$30 copayment (30 total visits per year for PT/OT combined)	70%, after deductible (30 total visits per year for PT/OT combined)
Speech	$15 copayment, no deductible	80%, after deductible	$20 copayment (20 visits per year)	70%, after deductible (20 visits per year)	$30 copayment (20 visits per year)	70%, after deductible (20 visits per year)
Cardiac rehabilitation	$15 copayment, no deductible (36 visits per year combined in/out of network)	80%, after deductible (36 visits per year combined in/out of network)	$20 copayment (36 visits per year)	70%, after deductible (36 visits per year)	$30 copayment (36 visits per year)	70%, after deductible (36 visits per year)
Pulmonary rehabilitation	$15 copayment, no deductible (12 visits per year combined in/out of network)	80%, after deductible (12 visits per year combined in/out of network)	$20 copayment (36 visits per year)	70%, after deductible (36 visits per year)	$30 copayment (36 visits per year)	70%, after deductible (36 visits per year)
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	$15 copayment, no deductible	80%, after deductible	$20 copayment (20 visits per calendar year)	70%, after deductible (20 visits per calendar year)	$30 copayment (20 visits per year)	70%, after deductible (20 visits per calendar year)
CHEMO/RADIATION/DIALYSIS	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%, after deductible	80%, after deductible	90% (360 hours per year)	70%, after deductible (360 hours per year)	90% (360 hours per year)	70%, after deductible (360 hours per year)
SKILLED NURSING FACILITY	100%, after deductible	80%, after deductible	100% (120 days per year)	70%, after deductible (60 days per year)	100% (120 days per year)	70%, after deductible (60 days per year)
HOSPICE AND HOME HEALTH CARE	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%, after deductible	80%, after deductible	100%	70%, after deductible	70%	50%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%, no deductible	Not covered	100%	Not covered	100%	Not covered
MENTAL HEALTH CARE						
Outpatient	$15 copayment, no deductible	80%, after deductible	$20 copayment	70%, after deductible	$30 copayment	70%, after deductible
Inpatient	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
SERIOUS MENTAL ILLNESS CARE						
Outpatient	$15 copayment, no deductible	80%, after deductible	$20 copayment	70%, after deductible	$30 copayment	70%, after deductible
Inpatient	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
SUBSTANCE ABUSE TREATMENT						
Outpatient/Partial facility visits	$15 copayment, no deductible	80%, after deductible	$20 copayment	70%, after deductible	$30 copayment	70%, after deductible
Inpatient Rehabilitation	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible
Inpatient Detoxification	100%, after deductible	80%, after deductible	100%	70%, after deductible	100%	70%, after deductible

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