

Benefits/Services	Keystone Point-of-Service (POS) ¹			Personal Choice - Basic Option (BC)			Personal Choice - High Option (HC)		
	Drexel Preferred	Keystone Network	Self-Referral Care	Drexel Preferred	In-Network	Out-of-Network	Drexel Preferred	In-Network	Out-of-Network
Deductible - Single/Family	\$0 / \$0	\$0 / \$0	\$500 / \$1,500	\$0 / \$0	\$300 / \$600	\$750 / \$1,500	\$0 / \$0	\$0 / \$0	\$500 / \$1,000
Co-Insurance	Not Applicable	Not Applicable	70% / 30%	Not Applicable	90% / 10%	70% / 30%	Not Applicable	Not Applicable	80% / 20%
Out-of-Pocket Limit - Single / Family	\$1,500 / \$3,000	\$2,000/\$4,000	N/A	\$1,000 / \$2,000	\$1,000 / \$2,000	\$3,000 / \$6,000	Not Applicable	Not Applicable	\$3,000 / \$6,000
Physician Office Visits - Primary Care Physician	\$0 Copay \$10 Copay	\$20 Copay \$40 Copay	70% after deductible 70% after deductible	\$0 Copay \$10 Copay	\$20 Copay \$30 Copay	70% after deductible 70% after deductible	\$0 Copay \$10 Copay	\$15 Copay \$25 Copay	80% after deductible 80% after deductible
Office Visits - Specialist									
Routine Physical	Covered 100%	Covered 100%	70% no deductible	Covered 100%	100% no deductible	70% no deductible	Covered 100%	Covered 100%	80% no deductible
GYN Exam	Covered 100%	Covered 100%	70% no deductible	Covered 100%	100% no deductible	70% no deductible	Covered 100%	Covered 100%	80% no deductible
Pediatric Immunizations	Covered 100%	Covered 100%	70% no deductible	Covered 100%	100% no deductible	70% no deductible	Covered 100%	Covered 100%	80% no deductible
Mammography	Covered 100%	Covered 100%	70% no deductible	Covered 100%	100% no deductible	70% no deductible	Covered 100%	Covered 100%	80% no deductible
Pap Smear	Covered 100%	Covered 100%	70% no deductible	Covered 100%	100% no deductible	70% no deductible	Covered 100%	Covered 100%	80% no deductible
Emergency Room	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)	\$75 Copay (waived if admitted)
Hospitalization	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	\$100/day; max of 5 copays per admission	70% after deductible	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	90% after deductible	70% after deductible	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	100%	80% after deductible
Outpatient Surgery	100%	\$50 Copay	70% after deductible	100%	90% after deductible	70% after deductible	100%	100%	80% after deductible
Outpatient Lab	100%	100%	70% after deductible	100%	100%, no deductible	70% after deductible	100%	100%	80% after deductible
Outpatient X-Ray/Radiology									
Routine Radiology/Diagnostic	Covered 100%	\$20 Copay	70% after deductible	Covered 100%	90% after deductible**	70% after deductible**	Covered 100%	100%**	80% after deductible**
MR/IMRA, CT/CTA Scan, PET Scan	Covered 100%	\$80 Copay	70% after deductible	Covered 100%	90% after deductible**	70% after deductible**	Covered 100%	100%**	80% after deductible**
Maternity									
First OB visit	\$10 Copay	\$20 Copay	70% after deductible	\$10 Copay	\$20 Copay	70% after deductible	\$10 Copay	\$15 Copay	80% after deductible
Hospital	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	\$100/day; max of 5 copays per admission	70% after deductible	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	90% after deductible	70% after deductible	\$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	100%	80% after deductible
Mental Health									
Inpatient	Only available in the KHPE Network	\$100/day; max of 5 copays per admission	70% after deductible	Only available in the PC Network	90% after deductible**	70% after deductible**	Only available in the PC Network	100%**	80% after deductible**
Outpatient	Only available in the KHPE Network	\$40 Copay**	70% after deductible	Only available in the PC Network	\$30 Copay, no deductible	70% after deductible**	Only available in the PC Network	\$25 Copay	80% after deductible**
Substance Abuse									
Detoxification	Only available in the KHPE Network	\$100/day; max of 5 copays per admission	70% after deductible	Only available in the PC Network	90% after deductible**	70% after deductible	Only available in the PC Network	100%**	80% after deductible**
Inpatient	Only available in the KHPE Network	\$100/day; max of 5 copays per admission	70% after deductible	Only available in the PC Network	90% after deductible**	70% after deductible	Only available in the PC Network	100%**	80% after deductible**
Outpatient	Only available in the KHPE Network	\$40 Copay**	70% after deductible	Only available in the PC Network	\$30 Copay, no deductible	70% after deductible	Only available in the PC Network	\$25 Copay	80% after deductible**
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Prescriptions	Retail - 30 Day Supply			Mail Order - 90 Day Supply					
	Generic								
	Formulary								
	Non-Formulary								
	\$5			\$10					
	\$15			\$30					
	\$30			\$60					

** Refer to the Summary Plan Description for annual, admission, and/or lifetime limits. Not available in all areas

This comparison chart is a summary of benefits only. In the event of a discrepancy between this document and any applicable insurance contract or plan document, the insurance contract or plan document will rule.