| BENEFIT PLAN NAME | Independence Blue Cross Personal Choice  
In Philadelphia, 215-557-7577  
Outside Philadelphia, 1-800-626-8144  
Group #53180 | Keystone Health Plan East Point of Service—PA, NJ, DE  
In Philadelphia, 215-241-2240  
Outside Philadelphia, 1-800-227-3115  
Group #416451 |
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<tr>
<td>DEPENDENT DEFINITION</td>
<td>Spouse and dependent children to age 26</td>
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| TYPE OF PLAN | **Preferred Provider Organization**  
Free Choice of Providers In & Out-of-Network  
Drexel Preferred: no deductible; $1,000 single, $2,000 family OOP maximum  
In Network: $300 single / $600 family deductible; $2,000 single, $4,000 family OOP maximum  
Out-of-Network: $1,000 single, $2,000 family deductible; $3,000 single, $6,000 family OOP Maximum  
Unlimited Lifetime Maximum: In-Network / Out-of-Network | **Point-of-Service Plan**  
Free Choice of Providers In & Out-of-Network  
Drexel Preferred: no deductible; $1,500 single, $3,000 family OOP maximum  
In Network: no deductible; $2,000 single, $4,000 family OOP maximum  
Out-of-Network (also called Self-Referred Care): $500 single, $1,500 family deductible; $3,000 single, $9,000 family OOP Maximum  
Unlimited Lifetime Maximum: In-Network / Out-of-Network |
| IN-PATIENT HOSPITAL | Covered 100% after $240 per-admission Preferred co-pay reimbursed at Tenet Facilities; In Network: 90% after deductible; Out-of-Network: 70% after deductible up to 70 days/year* | Covered 100% after $240 per-admission Preferred co-pay reimbursed at Tenet Facilities; Covered 100% after $100 co-pay per day, max 5 co-pays per admit KHPE network; Self-Referred: 70% after deductible |
| OUT-PATIENT EMERGENCY TREATMENT | $100 co-pay hospital – waived if admitted | $100 co-pay hospital – waived if admitted |
| PHYSICIAN VISITS OFFICE | Tenet Preferred Referred: $0 co-pay / visit; In Network: $20 co-pay / visit; Out-of-Network: 70% after deductible* | Tenet Preferred Referred: $0 co-pay / visit; KHPE Referred: $20 co-pay / visit; Self-Referred: 70%* after deductible |
| PHYSICIAN CARE SURGERY ANESTHESIA CONSULTANTS | For all items: Tenet Preferred and In-Network: 100%; Out-of-Network: 70% after deductible* | For all items: Tenet Preferred and KHPE Referred: Covered in full 100%; Self-Referred: 70%* |
| LABORATORY X-RAY AND CARDIOGRAM MAMMOGRAPHY | Tenet Preferred and In Network: 100%  
Out-of-Network: 70%* no deductible | Tenet Preferred and KHPE Referred: Covered in full  
Self-Referred: 70%* |
| MATERNITY CARE OB VISITS | Tenet Preferred Referred: $10 co-pay (1* visit)  
In Network: $20 co-pay (1* visit)  
Out of Network: 70% after deductible*  
Covered 100% after $240 per-admission Preferred co-pay reimbursed at Tenet Facilities; In Network: 90% after deductible; Out of Network: 70% after deductible*  
In Vitro Fertilization NOT covered | Tenet Preferred Referred: $10 co-pay (1* visit)  
KHPE Referred: $20 co-pay (1* visit)  
Self-Referred: 70%* after deductible*  
Covered 100% after $240 per-admission Preferred co-pay reimbursed at Tenet Facilities; Covered 100% after $100 co-pay per day, max 5 co-pays per admit KHPE network; Self-Referred: 70% after deductible  
In Vitro Fertilization NOT covered |
| PHYSICAL EXAM | In Network: $100%; Out of Network: 70% after deductible*  
In Network: $100%; Out of Network: 70%* No deductible (Child Imm. only)  
Not covered  
Not covered | In Network: $100%; Out of Network: 70% after deductible*  
In Network: $100%; Out of Network: 70%* No deductible (Child Imm. only)  
Vision Screening: $20 co-pay  
Hearing aids not covered |
| CHILDHOOD IMMUNIZATION | Not covered |
| EYE EXAMS | Not covered |
| EAR EXAMS | Not covered |
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Group #416451 |
|---|---|
| PREVENTIVE DENTAL CARE | Not covered  
Covered under separate Dental Plan options | Not covered  
Covered under separate Dental Plan options |
| MENTAL HEALTH INPATIENT | In Network: 90% after deductible ; Out of Network: 70% after deductible*  
Preauthorization required. | Covered 100% after $100 co-pay per day, max 5 co-pays per admit  
KHPE network; Self-Referred: 70% after deductible  
Pre-authorization required. |
| SERIOUS MENTAL ILLNESS INPATIENT | In Network: 90% after deductible ; Out of Network: 70% after deductible*  
Preauthorization required. | Covered 100% after $100 co-pay per day, max 5 co-pays per admit  
KHPE network; Self-Referred: 70% after deductible  
Pre-authorization required. |
| MENTAL HEALTH OUTPATIENT PHYSICIAN | In Network: $30 co-pay  
Out of Network: 70% after deductible* | TenetPreferred and KHPE Referred:  
$40 co-pay  
Self-Referred: 70% after deductible* |
| SERIOUS MENTAL ILLNESS OUTPATIENT PHYSICIAN | In Network: $30 co-pay  
Out of Network: 70% after deductible* | TenetPreferred and KHPE Referred:  
$40 co-pay  
Self-Referred: 70% after deductible* |
| SUBSTANCE ABUSE INPATIENT | Detox: In Network: 90% after deductible; Out of Network:70% after deductible  
Rehab: In Network: 90% after deductible; Out of Network:70% after deductible | Covered 100% after $100 co-pay per day, max 5 co-pays per admit  
KHPE network; Self-Referred: 70% after deductible |
| SUBSTANCE ABUSE OUTPATIENT | In Network: $30 co-pay  
Out of Network: 70% after deductible* | Tenet Preferred and KHPE Referred:  
$40 co-pay  
Self-Referred: 70% after deductible* |
| PRESCRIPTION (administered by Express Scripts) Some procedures / drugs in this plan require pre-certification. | The prescription drug program is not included under your health plan and operates as a separate benefit plan. Employees who choose a medical plan will be automatically enrolled in the prescription drug plan detailed below. |

**Retail (30 day supply)**
- Generic $10 Co-pay
- Preferred Brand $30 Co-pay
- Non – Preferred Brand $50 Co-pay

**Mail Order (90 day supply of maintenance drugs)**
- Generic $20 Co-pay
- Preferred Brand $60 Co-pay
- Non – Preferred Brand $100 Co-pay

This information is a summary only. The Plan Documents and the Summary Plan Descriptions (SPD’s) fully describe the plans. If there is any discrepancy between this information and the Plan Documents, the official Plan Documents will govern.