

Benefits/Services	Keystone Point-of-Service (POS)*			Personal Choice - Basic Option (BC)			Personal Choice - High Option (HC)			HDHP with HSA			
	Drexel Preferred	Keystone Network	Self-Referred Care	Drexel Preferred	In-Network	Out-of-Network	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	\$1,000 / \$2,000	\$0 / \$0	\$0 / \$0	\$500 / \$1,000	\$1,500 / \$3,000	\$2,000 / \$4,000	\$5,000 / \$10,000	
Co-Insurance	Not Applicable	Not Applicable	70% / 30%	Not Applicable	90% / 10%	70% / 30%	Not Applicable	Not Applicable	80% / 20%	100% after deductible	80% after deductible	50% after deductible	
Out-of-Pocket Limit - Single / Family	\$1,500 / \$3,000	\$2,000/\$4,000	\$3,000/\$9,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$1,000 / \$2,000	\$2,000 / \$4,000	\$3,000 / \$6,000	\$6,450 / \$12,900		\$10,000 / \$20,000	
Physician Office Visits - Primary Care Physician Office Visits - Specialist	\$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	100% after deductible 100% after deductible	80% after deductible 80% after deductible	50% after deductible 50% after deductible	
Routine Physical GYN Exam Pediatric Immunizations Mammography Pap Smear	Covered 100% Covered 100% Covered 100% Covered 100% Covered 100%	Covered 100% Covered 100% Covered 100% Covered 100% Covered 100%	70% no deductible 70% no deductible 70% no deductible 70% no deductible 70% no deductible	Covered 100% Covered 100% Covered 100% Covered 100% Covered 100%	100% no deductible 100% no deductible 100% no deductible 100% no deductible 100% no deductible	70% no deductible 70% no deductible 70% no deductible 70% no deductible 70% no deductible	Covered 100% Covered 100% Covered 100% Covered 100% Covered 100%	Covered 100% Covered 100% Covered 100% Covered 100% Covered 100%	80% no deductible 80% no deductible 80% no deductible 80% no deductible 80% no deductible	100% no deductible	100% no deductible	50% no deductible	
Emergency Room	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$100 Copay (waived if admitted)	100% after Drexel Preferred deductible	100% after Drexel Preferred deductible	100% after Drexel Preferred deductible	
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	100% after deductible	80% after deductible	70 days; 50% after deductible	
Outpatient Surgery	100%	\$50 Copay	70% after deductible	100%	90% after deductible	70% after deductible	100%	100%	80% after deductible	100% after deductible	80% after deductible	50% after deductible	
Outpatient Lab	100%	100%	70% after deductible	100%	100%, no deductible	70% after deductible	100%	100%	80% after deductible	100% after deductible	80% after deductible	50% 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**	100% after deductible	80% after deductible	50% after deductible	
MRI/MRA, 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**	100% after deductible	80% after deductible	50% after deductible	
Maternity First OB visit Hospital	\$10 Copay \$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	\$20 Copay \$100/day; max of 5 copays per admission	70% after deductible 70% after deductible	\$10 Copay \$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	\$20 Copay 90% after deductible	70% after deductible 70% after deductible	\$10 Copay \$0 at Hahnemann or St. Chris (\$240 copay reimbursed)	\$15 Copay 100%	80% after deductible 80% after deductible	100% after deductible 100% after deductible	80% after deductible 80% after deductible	50% after deductible 50% after deductible	
Mental Health Inpatient Outpatient	Only available in the KHPE Network Only available in the KHPE Network	\$100/day; max of 5 copays per admission \$40 Copay**	70% after deductible 70% after deductible	Only available in the PC Network Only available in the PC Network	90% after deductible** \$30 Copay, no deductible	70% after deductible** 70% after deductible**	Only available in the PC Network Only available in the PC Network	100%** \$25 Copay	80% after deductible** 80% after deductible**	Only available in the KHPE Network Only available in the KHPE Network	80% after deductible 80% after deductible	50% after deductible 50% after deductible	
Substance Abuse Detoxification Inpatient Outpatient	Only available in the KHPE Network Only available in the KHPE Network Only available in the KHPE Network	\$100/day; max of 5 copays per admission \$100/day; max of 5 copays per admission \$40 Copay**	70% after deductible 70% after deductible 70% after deductible	Only available in the PC Network Only available in the PC Network Only available in the PC Network	90% after deductible** 90% after deductible** \$30 Copay, no deductible	70% after deductible 70% after deductible 70% after deductible	Only available in the PC Network Only available in the PC Network Only available in the PC Network	100%** 100%** \$25 Copay	80% after deductible** 80% after deductible** 80% after deductible**	Only available in the PC Network Only available in the PC Network Only available in the PC Network	80% after deductible 80% after deductible 80% after deductible	50% after deductible 50% after deductible 50% after deductible	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Prescriptions Out-of-Pocket Limit - Single / Family	Retail - 30 Day Supply \$2,000 / \$4,000			Mail Order - 90 Day Supply \$2,000 / \$4,000						Retail - 30 Day Supply Combined with medical			Mail - 90 Day Supply Combined with medical
	Generic Formulary Non-Formulary			\$10 \$30 \$50	\$20 \$60 \$100						\$10 retail or \$20 mail; after deductible \$30 retail or \$60 mail; after deductible \$50 retail or \$100 mail; after deductible		
Includes University HSA Contrib - \$500/\$1,000													

* Not available in all areas

** Refer to the Summary Plan Description for annual, admission, and/or lifetime limits

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.