Benefits/Services	Keystone Point-of-Service (POS)[1]			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	$750 / $1,500	$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	$1,000 / $2,000	$3,000 / $6,000	$1,000 / $2,000	$1,000 / $2,000	$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	Covered 100%	100% no deductible	50% 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)	100% after INN deductible	100% after INN deductible	100% after INN 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 MRI/MRA, CT/CTA Scan, PET Scan	Covered 100% Covered 100%	$20 Copay $80 Copay	70% after deductible 70% after deductible	Covered 100% Covered 100%	90% after deductible** 90% after deductible**	70% after deductible** 70% after deductible**	Covered 100% Covered 100%	100%** 100%**	80% after deductible** 80% after deductible**	100% after deductible	80% after deductible 80% after deductible	50% 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	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	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			Retail - 30 Day Supply			Mail Order - 90 Day Supply				Retail - 30 Day Supply		Mail - 90 Day Supply
Out-of-Pocket Limit - Single / Family			$2,000 / $4,000			$2,000 / $4,000				Combined with medical		Combined with medical
Generic			$5			$10				$5 retail or $10 mail; after deductible		
Formulary			$15			$30				$20 retail or $40 mail; after deductible		
Non-Formulary			$30			$60				$45 retial or $90 mail; after deductible		
										Includes University HSA Contrib - $500/$1,000		

**** 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.