HAVERFORD COLLEGE PLAN COMPARISON 11/01/2011

COVERAGES	KEYSTONE 10 Health Maintenance Organization (HMO)	KEYSTONE 10B Point of Service (POS)		PERSONAL CHOICE 20/30/70 Preferred Provider Organization (PPO)		PERSONAL CHOICE HD1-HC1 High Deductible Health Plan (HDHP)	
		Referred	*Self-Referred*	*In Network*	*Out of Network*	*In Network*	*Out of Network*
Deductible Individual/Family	NONE	NONE	$200/$600	$0/$0	$500/$1,000	$1,500/$3,000	$5,000/$10,000
Out-of-Pocket Maximum Individual/Family	$1,000/$2,000	$1,000/$2,000	$1,000/$3,000	N/A	$3,000/$6,000	$5,600/$11,200	$10,000/$20,000
Lifetime Maximum	Unlimited	Unlimited	$1,000,000	Unlimited	1 Million	Unlimited	$500,000
Coinsurance	100%	100%	80%	100%	70%	100%, after ded	50%, after ded
Primary Care Office Visit	$10 Copay; *NO Copay for preventive care*	$10 Copay; *NO Copay for preventive care*	80%; *NO Copay for preventive care*	$20 Copay; *NO Copay for preventive care*	70%; *NO Copay for preventive care*	100% after deductible; *NO Copay for preventive care*	50% after ded; *NO Copay for preventive care*
Specialist Office Visit	$15 Copay	$15 Copay	80%	$30 Copay	70%	100% after ded	50% after ded
Maternity Care	$15 Copay, 1st visit	$15 Copay, 1st visit	80%	$20 Copay, 1st visit	70%	100%, after ded	50%, after ded
Pediatric Immunizations	100%	100%	80% NO ded	100%	70%, NO ded	100%, NO ded	50%, NO ded
Routine Gyn Exam/Pap	NO Copay/100%	NO Copay/100%	NO Copay/100%	NO Copay/100%	NO Copay/100%	NO Copay, NO ded	NO Copay, NO ded
Routine Mammography	100%	100%	80% NO ded	100%	70%, NO ded	100%. NO ded	50%, NO ded
Inpatient Hospital	$100 Copay/day max $500/admission	$100 Copay/day max $500/admission	80%	$150 Copay/day max $750 Copay /admission	70%	100% after ded	50% after ded
Inpatient Hospital Days	Unlimited	Unlimited	120	Unlimited	70	Unlimited	70
Emergency Room	$150 Copay	$150 Copay	$150 Copay	$150 Copay	$150 Copay	100% after ded	Covered at in-network level
Outpatient Laboratory/Radiology	100%	100%	80%	100% Lab/ $30 Copay Radiology	70%	100% after ded	50% after ded
Injectable Medications	100%	100%	80%	100%	70%	100% after ded	50% after ded
Outpatient Surgery	$50	$50 Copay	80%	$150 Copay	70%	100% after ded	50% after ded
Restorative Services	100% up to 60 consecutive days/condition	100% up to 60 consecutive days/condition	80% ($1,000 aggr max/yr)	$30 Copay; 30 visits/yr	70%; 30 visits/yr	100% after ded; 20 visits/benefit period	50% after ded; 20 visits/benefit period
Physical, Speech and Occupational Therapy	100% up to 60 consecutive days/condition	100% up to 60 consecutive days/condition	80% ($5,000 aggr max/yr)	$20 Copay [1-30] $30 Copay [31-60] 60 visits/yr	70% 70%	100% after ded; 60 visits/benefit period	50% after ded; 60 visits/benefit period
Cardiac Rehabilitation Therapy	100%	100%	80% ($5,000 aggr max/yr)	$20 Copay; 36 visits/yr	70%; 36 visits/yr	100% after ded; 36 visits/benefit period	50% after ded; 36 visits/benefit period
Pulmonary Rehabilitation	100%	100%	80% ($5,000 aggr max/yr)	$20 Copay; 12 visits/yr	70%; 12 visits/yr	100% after ded; 36 visits/benefit period	50% after ded; 36 visits/benefit period
Chemotherapy/Radiation	100%	100%	80%	100%	70%	100% after ded	50% after ded
Outpatient Private Duty Nursing	100%	100%	80%	100%; 360 hours/yr	70%; 360 hours/yr	100% after ded; 360 hours/benefit period	50% after ded; 360 hours/benefit period
Skilled Nursing Facility	100% 180 days/cal yr	100% up to 180 days	80% up to 240 days	100%; 120 days/yr	70%; 120 days/yr	100% after ded; 120 days/benefit period	50% after ded; 120 days/benefit period
Durable Medical Equipment and Prosthetics	100%	100%	80%	$30 Copay	70%	100% after ded	50% after ded ($2,500 benefit max/benefit period)
Inpatient Psychiatric (Days)	$100 Copay/day max $500/admission	$100 Copay/day max $500/admission	80%	$150 Copay/day max $750 Copay /admission	70%	100% after ded	50% after ded
Outpatient Psychiatric (Visits)	$15 Copay	$15 Copay	80%	$30 Copay	70%	100% after ded	50% after ded
Inpatient Serious Mental Illness (Days)	$100 Copay/day max $500/admission	$100 Copay/day max $500/admission	80%	$150 Copay/day max $750 Copay /admission	70%	100% after ded	50% after ded
Outpatient Serious Mental Illness (Visits)	$15 Copay	$15 Copay	80%	$30 Copay	70%	100% after ded	50% after ded
Substance Abuse-Detox	$100 Copay/day max $500/admission	$100 Copay/day max $500/admission	80%	$150 Copay/day max $750 Copay /admission	70%	100% after ded	50% after ded
Substance Abuse - Inpatient Rehab	$100 Copay/day max $500/admission	$100 Copay/day max $500/admission	80%	$150 Copay/day max $750 Copay /admission	70%	100% after ded	50% after ded
Substance Abuse - Outpatient & Partial	$15 Copay	$15 Copay	80%	$30 Copay	70%	100% after ded	50% after ded

IT SHOULD BE NOTED THAT THE COINSURANCE LIMITS FOR OUT-OF-NETWORK BENEFIT LEVELS APPLY AFTER THE DEDUCTIBLE HAS BEEN SATISFIED.

FOR SUMMARY PURPOSES ONLY. FOR PLAN DETAILS, PLEASE REFER TO PLAN BOOKLET.