

**BRYN MAWR COLLEGE
MEDICAL INSURANCE BENEFITS COMPARISON
EFFECTIVE NOVEMBER 1, 2008**

	Preferred Provider Organization (PPO) Coverage				Point-of-Service (POS) Coverage		HMO Coverage
BENEFITS	PERSONAL CHOICE HIGH OPTION PPO		PERSONAL CHOICE LOW OPTION PPO		KEYSTONE HEALTH PLAN EAST KEYSTONE POS		KEYSTONE HEALTH PLAN EAST KEYSTONE HMO
	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>REFERRED COVERAGE</i>	<i>SELF-REFERRED COVERAGE</i>	
<u>Description of Plan</u>	Provides comprehensive health services including preventive care (routine visits). Must use affiliated physicians and hospitals. Female members may select OB/GYN physician within the network.	Provides comprehensive health services using physicians and hospitals of your choice. Member will be responsible for an annual deductible and co-insurance.	Provides comprehensive health services including preventive care (routine visits). Must use affiliated physicians and hospitals. Female members may select OB/GYN physician within the network.	Provides comprehensive health services using physicians and hospitals of your choice. Member will be responsible for an annual deductible and co-insurance.	Provides comprehensive health services including preventive care (routine visits). Individuals select a "Primary Care Physician" and must use affiliated physicians and hospitals. Female members may select OB/GYN physician within the network.	Provides comprehensive health services using physicians and hospitals of your choice. Member will be responsible for an annual deductible and co-insurance.	Provides comprehensive health services including preventive care (routine visits.) Individuals select a "Primary Care Physician" and must use affiliated physicians and hospitals. Female members may select OB/GYN physician.
<u>Annual Deductible (January - December)</u> - Individual - Family	N/A N/A	\$500 \$1,000	N/A N/A	\$1,500 \$4,500	N/A N/A	\$200 \$600	N/A N/A
<u>Out of Pocket Limit*</u> - Individual - Family	N/A N/A	\$3,000 \$6,000	N/A N/A	\$10,000 \$30,000	N/A N/A	\$1,000 \$3,000	N/A N/A
<u>Hospitalization Room and Board</u>	Covered in full-365 days. Pre-certification required and is the hospital's responsibility.	70% of allowed charges** after deductible; for 70 days per calendar year. Pre-certification required and is the member's responsibility or benefits will be reduced.	\$100 co-payment per day to a maximum of 5 days per 90-day period, then covered in full-no limits. Pre-certification required and is the hospital's responsibility.	50% of allowed charges** after deductible; for 70 days per calendar year. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full - no limits. Pre-certification is required and is the primary care physician's responsibility.	80% of allowed charges** after deductible for 120 days per calendar year. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full - no limits. Pre-certification is required and is the primary care physician's responsibility.
<u>Outpatient Surgery (facility)</u>	Covered in full. Pre-certification required and is the hospital's responsibility for certain procedures.	70% of allowed charges** after deductible. Pre-certification by the member required for certain procedures or benefits will be reduced.	\$50 co-payment. Pre-certification required and is the hospital's responsibility for certain procedures.	50% of allowed charges** after deductible. Pre-certification by the member required for certain procedures or benefits will be reduced.	Covered in full. Pre-certification required and is the primary care physician's responsibility for certain procedures.	80% of allowed charges** after deductible. Pre-certification by the member required for certain procedures or benefits will be reduced.	Covered in full. Pre-certification required and is the primary care physician's responsibility for certain procedures.
<u>Physician Services</u> • <u>Surgery (Inpatient/ Outpatient)</u>	Must use Personal Choice affiliated specialist. Covered in full.	70% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Must use Personal Choice affiliated specialist. Covered in full.	50% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Must use Keystone affiliated specialist. Covered in full.	80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Must use Keystone affiliated specialist. Covered in full.

*The out of pocket limit includes coinsurance paid by the subscriber, but excludes deductibles, amounts in excess of allowed charges, penalties and mental health expenses.

**Allowed charges are based on the payments made to an in-network provider. You are responsible for amounts in excess of the allowed charges.

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BENEFITS	HIGH OPTION		LOW OPTION		KEYSTONE HEALTH PLAN EAST KEYSTONE POS		KEYSTONE HEALTH PLAN EAST KEYSTONE HMO
	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>REFERRED COVERAGE</i>	<i>SELF-REFERRED COVERAGE</i>	<i>REFERRED COVERAGE</i>
<u>Physician Services</u> • Inpatient Visits	Covered in full.	70% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full.	50% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full.	80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full.
<u>Physician Services</u> • Office Visits	\$20.00 co-payment per primary care visit. Includes periodic physicals (frequency determined by age). \$30 co-payment for specialist visits.	70% of allowed charges** after deductible.	\$15.00 co-payment per primary care visit. Includes periodic physicals (frequency determined by age). \$30 co-payment for specialist visits.	50% of allowed charges** after deductible	\$10.00 co-payment for primary care physician and \$15 for referred specialists. Includes periodic physicals (frequency determined by age). \$15 co-pay for after-hour and home visits by primary care physician.	80% of allowed charges** after deductible.	\$10.00 co-payment for primary care physician and \$15 for referred specialists. Includes periodic physicals (frequency determined by age). \$15 co-pay for after-hour and home visits by primary care physician.
<u>Laboratory, X-Ray and Routine Radiology Services</u>	Covered subject to \$30 co-payment for visits to affiliated facilities. No co-pay for laboratory services. Co-pay not applicable when performed in ER or office setting.	70% of allowed charges** after deductible.	Covered subject to \$30 co-payment for visits to affiliated facilities. No co-pay for laboratory services. Co-pay not applicable when performed in ER or office setting.	50% of allowed charges** after deductible.	Covered in full. Must use facilities affiliated with primary care physician.	80% of allowed charges** after deductible.	Covered in full. Must use facilities affiliated with primary care physician.
<u>MRI/MRA, CT/CTA Scan, PET Scan</u>	Covered subject to \$30 co-payment for visits to affiliated facilities. Pre-certification required and is the doctor's responsibility.	70% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered subject to \$60 co-payment for visits to affiliated facilities. Pre-certification required. and is the doctor's responsibility.	50% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Must use facilities affiliated with primary care physician. Pre-certification required and is the primary care physician's responsibility.	80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Must use facilities affiliated with primary care physician. Pre-certification required and is the primary care physician's responsibility.
<u>Outpatient Private Duty Nursing</u>	Covered in full, limited to 360 hours per calendar year (combined in and out-of-network). Pre-certification required and is the doctor's responsibility.	70% of allowed charges** after deductible, limited to 360 hours per calendar year (combined in and out-of-network). Pre-certification required and is the member's responsibility or benefits will be reduced.\	90% , limited to 360 hours per calendar year (combined in and out-of-network). Pre-certification required and is the doctor's responsibility.	50% of allowed charges** after deductible, limited to 360 hours per calendar year (combined in and out-of-network). Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Pre-certification required and is the primary care physician's responsibility.	80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Pre-certification required and is the primary care physician's responsibility.
<u>Skilled Nursing Facility</u>	Covered in full, limited to 180 days. Pre-certification required and is the doctor's responsibility.	70% of allowed charges** after deductible, limited to 240 days Pre-certification required and is the member's responsibility or benefits will be reduced.	\$50 co-pay per day to a max of 5 days per admission, then in full, limited to 120 days per calendar year (combined in and out-of-network) Pre-certification required and is the doctor's responsibility.	50% of allowed charges** after deductible, limited to 120 days per calendar year (combined in and out-of-network). Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full, limited to 180 days per calendar year. Pre-certification required and is the primary care physician's responsibility.	80% of allowed charges** after deductible, limited to 240 days per calendar year. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full, limited to 180 days per calendar year. Pre-certification required and is the primary care physician's responsibility.

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	HIGH OPTION		LOW OPTION		REFERRED COVERAGE	SELF-REFERRED COVERAGE	KEYSTONE HEALTH PLAN EAST KEYSTONE HMO
	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE			
<u>Home Health Care</u>	Covered in full. Pre-certification required and is the doctor's responsibility	70% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Pre-certification required and is the doctor's responsibility	50% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full. Pre-certification required and is the primary care physician's responsibility.	80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced.	Covered in full.
<u>Mammograms</u>	Female members age 40 or older -- one routine mammogram every calendar year. Female member under age 40 if recommended by physician.	70% of allowed charges**, no deductible.	Female members age 40 or older -- one routine mammogram every calendar year. Female member under age 40 if recommended by physician.	50% of allowed charges**, no deductible	Covered in full.	80% of allowed charges**, no deductible.	Covered in full.
<u>Routine Eye Examinations</u>	Covered in full every 2 years. Cannot combine in-network and out-of-network benefit.	\$35 payment every 2 years. Cannot combine in-network and out-of-network benefit.	Covered in full every 2 years. Cannot combine in-network and out-of-network benefit.	\$35 payment every 2 years. Cannot combine in-network and out-of-network benefit.	Covered in full after \$15 co-payment every 2 years. No referral needed.	Not Covered.	Covered in full after \$15 co-payment every 2 years. No referral needed.
<u>Eye Glasses and Contact Lenses</u>	Basic glasses and frames covered every 2 years. Cannot combine in-network and out-of-network benefit.	\$75 payment every 2 years. Cannot combine in-network and out-of-network benefit.	Basic glasses and frames covered every 2 years. Cannot combine in-network and out-of-network benefit.	\$75 payment every 2 years. Cannot combine in-network and out-of-network benefit.	Basic glasses and frames covered every 2 years. Cannot combine referred and self-referred benefit.	\$100 reimbursement towards the purchase of eyeglasses or contact lenses every 2 years. Cannot combine referred and self-referred benefit.	Same as Keystone POS, including the self-referred option.
<u>Dental Care</u>	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.
<u>Durable Medical Equipment and Prosthetics</u>	\$30 co-payment. Pre-certification required for purchases exceeding \$500 and most rentals.	70% of allowed charges** after deductible. Pre-certification required for purchases exceeding \$500 and most rentals. Benefit will be reduced if pre-certification is not obtained.	70%. Pre-certification required for purchases exceeding \$500 and most rentals..	50% of allowed charges** after deductible. Pre-certification required for purchases exceeding \$500 and most rentals. \$2,500 benefit maximum per calendar year. Benefit will be reduced if pre-certification is not obtained.	100%. Pre-certification required for purchases exceeding \$500 and most rentals.	80% of allowed charges** after deductible. Pre-certification required for purchases exceeding \$500 and most rentals. Benefit will be reduced if pre-certification is not obtained.	100%. Pre-certification required for purchases exceeding \$500 and most rentals.

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	HIGH OPTION		LOW OPTION		REFERRED COVERAGE	SELF-REFERRED COVERAGE	
	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE			
<u>Emergency Care</u>	Covered after \$40.00 co-pay, waived if admitted. Certification must occur within 2 days of an inpatient admission resulting from the emergency.	Covered at the in-network level.	Covered after \$100 co-pay, not waived if admitted.	Covered at the in-network level.	Must try to contact primary care physician before going to the emergency room (unless a life-threatening emergency). \$35.00 co-pay, waived if admitted.	Same as referred coverage.	Must try to contact primary care physician before going to the emergency room (unless a life-threatening emergency). \$35.00 co-pay, waived if admitted.
<u>Preventive Care Routine Physicals</u>	A \$20.00 co-pay; coverage provided for one routine history and physical examination every 3 years age 18-49; and one exam each year beginning at age 50.	70% of allowed charges** after deductible.	A \$15.00 co-pay; coverage provided for one routine history and physical examination every 3 years age 18-49; and one exam each year beginning at age 50.	50% of allowed charges** after deductible.	\$10.00 co-pay - primary care physician.	80% of allowed charges**, no deductible	\$10.00 co-pay - primary care physician.
<u>Well Baby Care (Check-ups & Immunizations)</u>	A \$20.00 co-pay; coverage is provided for one exam and necessary immunizations per schedule of age groupings.	70% of allowed charges** after deductible.	A \$15.00 co-pay; coverage is provided for one exam and necessary immunizations per schedule of age groupings.	50% of allowed charges** after deductible.	\$10.00 co-pay - primary care physician.	80% of allowed charges**, no deductible	\$10.00 co-pay - primary care physician.
<u>Routine Gynecological Exam and Pap Test</u>	Covered in full for one visit per calendar year.	70% of allowed charges** no deductible for one visit per calendar year. Not covered if already obtained in-network.	A \$15.00 co-pay for one visit per calendar year	50% of allowed charges** no deductible for one visit per calendar year. Not covered if already obtained in-network.	\$15 co-pay. No referral needed for two routine visits per calendar year.	80% of allowed charges**, no deductible for one visit per calendar year. Not covered if already obtained in-network.	\$15 co-pay. No referral needed for two routine visits per calendar year.
<u>Infertility Treatment</u>	Not Covered	Not Covered	Not Covered	Not Covered	Artificial insemination is covered subject to pre-certification that is the primary care physician's responsibility. Other assisted fertility treatments are not covered.	Artificial insemination is covered subject at 80% of allowed charges** after deductible. Pre-certification required and is the member's responsibility or benefits will be reduced. Other assisted fertility treatments are not covered.	Artificial insemination is covered subject to pre-certification that is the primary care physician's responsibility. Other assisted fertility treatments are not covered.
<u>Birth Control</u>	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visits benefit.	Oral contraceptives covered under prescription drug benefit. Insertion/removal of IUD and Norplant and fitting of diaphragm covered under office visit benefit.

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BENEFITS	HIGH OPTION		LOW OPTION		KEYSTONE HEALTH PLAN EAST KEYSTONE POS		KEYSTONE HEALTH PLAN EAST KEYSTONE HMO
	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>REFERRED COVERAGE</i>	<i>SELF-REFERRED COVERAGE</i>	
<u>Prescription Drugs</u> (outpatient)	\$10 generic, \$20 brand name formulary, \$35 brand name non-formulary, per prescription when purchased at a participating pharmacy. Mail-order option.	30% at non-participating pharmacies	\$15 generic, \$35 brand name formulary, \$50 brand name non-formulary, per prescription when purchased at a participating pharmacy. Mail-order option.	30% at non-participating pharmacies	\$5 generic, \$10 brand name formulary and \$25 brand name non-formulary, per prescription when purchased at a participating pharmacy. Mail-order option.	Same as referred coverage if purchased at a participating pharmacy. Otherwise, 30%.	\$5 generic, \$10 brand name formulary and \$25 brand name non-formulary, per prescription when purchased at a participating pharmacy. Otherwise, 30%. Mail-order option.
<u>Physical Therapy</u>	\$20 co-pay visits 1-30. \$30 co-pay visits 31-60.	70% of allowed charges** after deductible.	\$30 co-pay for 60 visits.	50% of allowed charges** after deductible.	Covered in full for 60 days per condition. Must use physical therapist affiliated with primary care physician.	80% of allowed charges** after deductible subject to \$5,000 annual limit for all outpatient therapy.	Covered in full for 60 days per condition. Must use physical therapist affiliated with primary care physician.
<u>Spinal Manipulations</u>	\$30 co-pay, 30 visits per year (combined in and out-of-network).	70% of allowed charges** after deductible, 30 visits per year (combined in and out-of-network).	\$30 co-pay, 20 visits per year (combined in and out-of-network).	50% of allowed charges** after deductible, 20 visits per year (combined in and out-of-network).	Covered in full for 60 days per condition. Referral required.	80% of allowed charges** after deductible subject to \$1,000 annual limit.	Covered in full for 60 days per condition. Referral required.
<u>Mental Health Care</u> (Inpatient)	Serious Mental Illness (SMI): Covered in full for 30 days per 365 day period with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a max of 60 days). Non-SMI: 30 days per 365 day period.	Serious Mental Illness (SMI): Covered for 30 days per 365 day period at 70% of allowed charges** after deductible with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a maximum of 60 days). Non-SMI: Covered for 20 days per 365 day period at 70% of allowed charges** after deductible. Pre-certification is required.	Serious Mental Illness (SMI): \$100 co-payment per day to a maximum of 5 days per 90-day period, then covered in full for 30 days per 365 day period with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a max of 60 days). Non-SMI: 30 days per 365 day period.	Serious Mental Illness (SMI): Covered for 30 days per 365 day period at 50% of allowed charges** after deductible with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a maximum of 60 days). Non-SMI: Covered for 20 days per 365 day period at 50% of allowed charges** after deductible. Pre-certification is required.	Serious Mental Illness (SMI): Covered in full for 30 days per calendar year with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a max of 60 days). Non-SMI: Covered in full for 35 days per calendar year.	Serious Mental Illness (SMI): 80% of allowed charges** after deductible for 30 days per calendar year with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a max of 60 days). Non-SMI: 80% of allowed charges** after deductible for 30 days per calendar year.	Serious Mental Illness (SMI): Covered in full for 30 days per calendar year with 1:2 trade (1 inpatient day may be traded for 2 outpatient days, to a max of 60 days). Non-SMI: Covered in full for 35 days per calendar year.
(Outpatient)	Serious Mental Illness (SMI): 60 visits per 365 day period. \$30 co-pay. Non-SMI: 30 visits per 365 day period. \$30 co-pay.	Serious Mental Illness (SMI): 60 visits per 365 day period at 50% of allowed charges** after deductible. Non-SMI: 20 visits per 365 day period at 50% of allowed charges*** after deductible.	Serious Mental Illness (SMI): 60 visits per 365 day period. \$30 co-pay. Non-SMI: 30 visits per 365 day period. \$30 co-pay.	Serious Mental Illness (SMI): 60 visits per 365 day period at 50% of allowed charges** after deductible. Non-SMI: 20 visits per 365 day period at 50% of allowed charges*** after deductible.	Serious Mental Illness (SMI): 60 visits per calendar year. \$25 co-payment. Non-SMI: 20 visits per calendar year. \$25 co-payment.	Serious Mental Illness (SMI) and Non-SMI: 50% of allowed charges** after deductible, limited to \$30 per visit. 60 visits per calendar year.	Serious Mental Illness (SMI): 60 visits per calendar year. \$25 co-payment. Non-SMI: 20 visits per calendar year. \$25 co-payment.
<u>Lifetime Maximum</u>	Unlimited	\$1,000,000	Unlimited	\$500,000	Unlimited	\$1,000,000	Unlimited

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