

**BRYN MAWR COLLEGE
MEDICAL INSURANCE BENEFITS COMPARISON
EFFECTIVE NOVEMBER 1, 2007**

	PERSONAL CHOICE PPO						HMO Coverage
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>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. Approval by Blue Cross is required and is the hospital's responsibility.	70% of allowed charges***; for 70 days per calendar year. Approval by Blue Cross is required and is the member's responsibility.	\$100 co-payment per day to a maximum of 5 days per 90-day period, then covered in full-no limits. Approval by Blue Cross is required and is the hospital's responsibility.	50% of allowed charges***; for 70 days per calendar year. Approval by Blue Cross is required and is the member's responsibility.	Covered in full - no limits. Approval by Keystone is required and is the primary care physician's responsibility.	80% of UCR**; approval by Keystone is required and is the member's responsibility.	Covered in full - no limits. Approval by Keystone is required and is the primary care physician's responsibility.

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

**Usual, customary and reasonable charges. You are responsible for amounts in excess of the UCR.

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

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	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>	<i>IN-NETWORK COVERAGE</i>	<i>OUT-OF-NETWORK COVERAGE</i>			
Physician Services • Surgery (Inpatient/ Outpatient)	Must use Personal Choice affiliated specialist. Covered in full.	70% of allowed charges*** after deductible. Benefit will be reduced if pre-certification is not obtained.	Must use Personal Choice affiliated specialist. Covered in full.	50% of allowed charges*** after deductible. Benefit will be reduced if pre-certification is not obtained.	Must use Keystone affiliated specialist. Covered in full.	80% of UCR** after deductible. Benefit will be reduced if pre-certification is not obtained.	Must use Keystone affiliated specialist. Covered in full.
Physician Services • Inpatient Visits	Covered in full.	70% of allowed charges*** after deductible.	Covered in full.	50% of allowed charges*** after deductible.	Covered in full.	80% of UCR** after deductible.	Covered in full.
Physician Services • 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 specialists. Includes periodic physicals (frequency determined by age). \$15 co-pay for after-hour and home visits by primary care physician.	80% of UCR** after deductible.	\$10.00 co-payment for primary care physician and \$15 for specialists. Includes periodic physicals (frequency determined by age). \$15 co-pay for after-hour and home visits by primary care physician.
Laboratory, X-Ray and Routine Radiology Services	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. Benefit will be reduced if pre-certification from Blue Cross is not obtained.	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. Benefit will be reduced if pre-certification from Blue Cross is not obtained.	Covered in full. Must use facilities affiliated with primary care physician.	80% of UCR** after deductible. Benefit will be reduced if pre-certification from Keystone is not obtained.	Covered in full. Must use facilities affiliated with primary care physician.
MRI/MRA, CT/CTA Scan, PET Scan	Covered subject to \$30 co-payment for visits to affiliated facilities. Pre-certification required.	70% of allowed charges*** after deductible. Benefit will be reduced if pre-certification from Blue Cross is not obtained.	Covered subject to \$60 co-payment for visits to affiliated facilities. Pre-certification required.	50% of allowed charges*** after deductible. Benefit will be reduced if pre-certification from Blue Cross is not obtained.	Covered in full. Must use facilities affiliated with primary care physician. Pre-certification required.	80% of UCR** after deductible. Benefit will be reduced if pre-certification from Keystone is not obtained.	Covered in full. Must use facilities affiliated with primary care physician. Pre-certification required.
Outpatient Private Duty Nursing	Covered in full, limited to 360 hours per calendar year (combined in and out-of-network).	70% of allowed charges*** after deductible, limited to 360 hours per calendar year (combined in and out-of-network).	90% of allowed charges, limited to 360 hours per calendar year (combined in and out-of-network).	50% of allowed charges*** after deductible, limited to 360 hours per calendar year (combined in and out-of-network).	Covered in full.	80% of UCR** after deductible. Benefit will be reduced if pre-certification from Keystone is not obtained.	Covered in full

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	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE				
Skilled Nursing Care	Covered in full, limited to 120 days per calendar year (combined in and out-of-network).	70% of allowed charges*** after deductible, limited to 120 days per calendar year (combined in and out-of-network).	\$100 co-payment per day to a maximum of 5 days per admission, then covered in full, limited to 120 days per calendar year (combined in and out-of-network)	50% of allowed charges*** after deductible, limited to 120 days per calendar year (combined in and out-of-network).	Covered in full, limited to 160 days per calendar year.	80% after deductible**, limited to 240 days per calendar year.	Covered in full, limited to 160 days per calendar year.	
Mammograms	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%, no deductible.	Covered in full.	
Routine Eye Examinations	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.	
Eye Glasses and Contact Lenses	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.	
Dental Care	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.	Not Covered.	
Durable Medical Equipment and Prosthetics	\$30 co-payment	70% of allowed charges*** after deductible. Pre-certification required for purchases exceeding \$100.	70% of allowed charges	50% of allowed charges*** after deductible. Pre-certification required for purchases exceeding \$100. \$2,500 benefit maximum per calendar year.	100%	80% of UCR** after deductible. Pre-certification required.	100%	
Birth Control	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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<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 UCR**, 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 UCR**, 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 UCR**, 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>Prescription Drugs (outpatient)</u>	\$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.

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	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE	REFERRED COVERAGE	SELF-REFERRED COVERAGE	
Physical Therapy	\$20 co-pay visits 1-30. \$30 co-pay visits 31-60. Pre-certification is required.	70% of allowed charges*** after deductible. Pre-certification is required.	\$30 co-pay for 60 visits. Pre-certification is required.	50% of allowed charges*** after deductible. Pre-certification is required.	Covered in full for 60 days per condition.	80% UCR** after deductible subject to \$5,000 annual limit for all outpatient therapy.	Covered in full for 60 days per condition.
Spinal Manipulations	\$30 co-pay, 30 visits per year. Pre-certification is required.	70% of allowed charges*** after deductible. Pre-certification is required.	\$30 co-pay, 20 visits per year (combined in and out-of-network). Pre-certification is required.	50% of allowed charges*** after deductible, 20 visits per year (combined in and out-of-network). Pre-certification is required.	Covered in full for 60 days per condition.	80% UCR**after deductible subject to \$1,000 annual limit.	Covered in full for 60 days per condition.
Mental Health Care (Inpatient)	<p>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).</p> <p>Non-SMI: 30 days per 365 day period.</p>	<p>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).</p> <p>Non-SMI: Covered for 20 days per 365 day period at 70% of allowed charges*** after deductible. Pre-certification is required.</p>	<p>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).</p> <p>Non-SMI: 30 days per 365 day period.</p>	<p>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).</p> <p>Non-SMI: Covered for 20 days per 365 day period at 50% of allowed charges*** after deductible. Pre-certification is required.</p>	<p>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).</p> <p>Non-SMI: Covered in full for 35 days per calendar year.</p>	<p>Serious Mental Illness (SMI): 80% of UCR** 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).</p> <p>Non-SMI: 80% of UCR** after deductible for 30 days per calendar year.</p>	<p>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).</p> <p>Non-SMI: Covered in full for 35 days per calendar year.</p>
(Outpatient)	<p>Serious Mental Illness (SMI): 60 visits per 365 day period. \$30 co-pay.</p> <p>Non-SMI: 30 visits per 365 day period. \$30 co-pay.</p>	<p>Serious Mental Illness (SMI): 60 visits per 365 day period at 50% of allowed charges*** after deductible.</p> <p>Non-SMI: 20 visits per 365 day period at 50% of allowed charges*** after deductible.</p>	<p>Serious Mental Illness (SMI): 60 visits per 365 day period. \$30 co-pay.</p> <p>Non-SMI: 30 visits per 365 day period. \$30 co-pay.</p>	<p>Serious Mental Illness (SMI): 60 visits per 365 day period at 50% of allowed charges*** after deductible.</p> <p>Non-SMI: 20 visits per 365 day period at 50% of allowed charges*** after deductible.</p>	<p>Serious Mental Illness (SMI): 60 visits per calendar year. \$25 co-payment.</p> <p>Non-SMI: 20 visits per calendar year. \$25 co-payment.</p>	<p>Serious Mental Illness (SMI) and Non-SMI: 50% of UCR** after deductible, limited to \$30 per visit. 60 visits per calendar year.</p>	<p>Serious Mental Illness (SMI): 60 visits per calendar year. \$25 co-payment.</p> <p>Non-SMI: 20 visits per calendar year. \$25 co-payment.</p>
Lifetime Maximum	Unlimited	\$1,000,000	Unlimited	\$500,000	Unlimited	\$1,000,000	Unlimited

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