Community College of Philadelphia Benefit Comparison
Effective 9/1/2022

Benefits	KPOS		Personal Choice	
	(Referred Care)	(Self-Referred Care)	(In Network)	(Out of Network)
Deductible				
Individual	$500	$500	$500	$700
Two People	$1,000	$1,000	$1,000	$1,400
Family	$1,500	$1,500	$1,500	$2,100
Coinsurance	100%	80%	100%	70%
Coinsurance Limit				
Individual	N/A	$2,000	N/A	$1,500
Family	N/A	$6,000	N/A	$4,500
Out of Pocket Maximum (includes deductible, copayments and coinsurance)				
Individual	$4,500	N/A	$4,500	N/A
Family	$9,000	N/A	$9,000	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Copay Maximum	$650/Member	N/A	N/A	N/A
Primary Care Physician				
Office Hours	$10 Copay, no deductible	80%, after deductible	$10 Copay, no deductible	70%, after deductible
After Hours/Home Visits	$10 Copay, no deductible	80%, after deductible	$10 Copay, no deductible	70%, after deductible
Pediatric Immunizations	Covered 100%, no deductible	80%, no deductible	Covered 100%, no deductible	70%, no deductible
Specialty Care				
Office Visits	$25 Copay, no deductible	80%, after deductible	$40 Copay, no deductible	70%, after deductible
Routine Gyn/Pap	Covered 100%, no deductible	80%, no deductible	Covered 100%, no deductible	70%, no deductible
Laboratory and X-Ray Services				
Outpatient Laboratory	Covered 100%, no deductible	80%, after deductible	Covered 100%, no deductible	70%, after deductible
Outpatient Radiology/Diagnostic+++	Covered 100%, no deductible	80%, after deductible	$20 Copay, no deductible	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	Covered 100%, no deductible	80%, after deductible	$40 Copay, no deductible	70%, after deductible
Routine Mammography	Covered 100%, no deductible	80%, no deductible	Covered 100%, no deductible	70%, no deductible
Acupuncture	$25 Copay, no deductible (Up to 18 visits)	80%, after deductible (Up to 18 visits)	$40 Copay, no deductible (Up to 18 visits****)	70%, after deductible
Maternity				
First OB Visit	$10 Copay, no deductible	80%, after deductible	$10 Copay, no deductible	70%, after deductible
Delivery	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%, after deductible
Hospital	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Inpatient Hospitalization Services+++	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Surgery and Anesthesia	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%, after deductible
Medical and Surgical Specialist	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%, after deductible
Diagnostic Testing	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%, after deductible
Inpatient Hospital Days	Unlimited	120 Days/Plan Year[2]	Unlimited	70 Days[3]
Emergency Room	$35 Copay, no deductible (Waived if admitted)	$35 Copay, no deductible (Waived if admitted)	$100 Copay, no deductible (Not waived if admitted)	$100 Copay, no deductible (Not waived if admitted)
Urgent Care Center	$24 Copay, no deductible	80%, after deductible	$70 Copay, no deductible	70%, after deductible
Outpatient Surgery* **	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%, after deductible
Outpatient Therapy Services (st*,ot,pt)**	Covered 100%, no deductible (Up to 60 consecutive days per condition)	80%, after deductible	$20 Copay, no deductible	70%, after deductible
Restorative Services/Spinal Manipulations	Covered 100%, no deductible (Up to 60 consecutive days per condition)	80%, after deductible	$40 Copay, no deductible	70%, after deductible
Skilled Nursing Facility* **	Covered 100%, after deductible (Up to 180 days)	80%, after deductible (Up to 240 days)	Covered 100%, after deductible (Up to 120 days)	70%, after deductible
Routine Eye Exam	Covered 100% with $25 Copay Once every 2 years	Covered as Referred Service Only	N/A	N/A
Home Health Care* **	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	70%,after deductible
Durable Medical Equipment* [1]**	Covered 100%, after deductible	80%, after deductible	Covered 100%, after deductible	50%, after deductible
Mental Health				
Inpatient***	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Outpatient	$25 Copay, no deductible	80%, after deductible	$40 Copay, no deductible	80%, after deductible
Serious Mental Illness (SMI)				
Inpatient***	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Outpatient	$25 Copay, no deductible	80%, after deductible	$40 Copay, no deductible	80%, after deductible
Substance Abuse				
Inpatient Detoxification***	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Outpatient Detoxification***	$25 Copay, no deductible	80%, after deductible	$40 Copay, no deductible	70%, after deductible
Inpatient Rehabilitation***	Covered 100%, after deductible	80%, after deductible[2]	Covered 100%, after deductible	70%, after deductible[3]
Outpatient Rehabilitation***	$25 Copay, no deductible	80%, after deductible	$40 Copay, no deductible	70%, after deductible

* This chart is a highlight of benefits available. All benefits are provided in accordance with the group contracts. For a complete list of benefits, limitations and exclusions, please see your member handbook or booklet/certificate.
**To receive maximum benefits, services must be provided or referred by your Keystone Health Plan East Primary Care Physician.
***Pre-authorization required
****Combined In/Out-of-Network
+ Office visit subject to copay
++Out-of-Network providers may bill you for any difference between the Plan allowance, which is the amount paid by the Plan, and the provider's actual charge. This amount may be significant.
+++MRI, MRA, CT/CTA Scan, PET Scan and Nuclear Cardiac Studies require pre-authorization. and detoxification services.
1 Includes Diabetic Supplies
2 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, maternity, mental health, serious mental illness, substance abuse and detoxification services.

After deductible: Member must pay deductible before the plan pays any benefits. A single member must meet the first $500 in expense before the plan pays noted percentage of coverage. An employee and child, or an employee and spouse must each meet separate $500 deductibles before the plan pays the noted percentage of coverage. For family deductible, an employee and children, or an employee and family must meet the individual deductible amount before the plan pays noted percentage of coverage. Once a family member meets the individual deductible amount, claims for that individual will pay; once the family deducible is met, claims for all individuals pay. Once a family member reaches their individual deductible, their out-of-pocket expenses no longer count towards the family deductible. No family member can contribute more than the individual deductible to the family deductible. As a note, there are higher deductibles in effect for self-referred care in the KPOS plan, and out-of-network care in the Personal Choice plan.