

Medical Plan Comparison Chart: Non-Medicare Participants/Dependents

Plan Name	Aetna HMO*	Keystone/ AmeriHealth HMO*	PennCare/ Personal Choice*		
	HMO Providers	HMO Providers	PennCare Providers	Personal Choice Providers	Non-Preferred Providers
Plan Year Deductible	None	None	\$100 individual \$300 family	\$250 individual \$750 family	\$500 individual \$1,500 family
Out-of-Pocket Maximum	\$1,000 individual \$2,000 family	\$1,000 individual \$2,000 family	\$1,000 individual \$3,000 family	\$2,500 individual \$7,500 family	\$3,500 individual \$10,500 family
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Office Visits	\$25 copay	\$25 copay	\$20 copay	\$25 copay	40% after deductible
Specialist Office Visits	\$35 copay with referral	\$35 copay with referral	\$30 copay	\$40 copay	40% after deductible
Hospitalization	\$350 copay per admission with referral; no max limit with coordination by patient mgmt dptmt	\$350 copay per admission; no max limit if medically necessary	10% after deductible	20% after deductible	40% after deductible; limited to 70 days
Routine Physical, Hearing Exam, & Annual GYN Exam/Pap Smear	\$0 copay	\$0 copay	\$0 copay	\$0 copay	40% no deductible
Routine Eye Exam	\$0 copay	\$35 copay**	\$0 copay	\$0 copay	40%; no deductible
Pediatric Well Exams & Immunizations	\$0 copay	\$0 copay	\$0 copay (under age 18)	\$0 copay (under age 18)	40%; no deductible (under age 18)
Mammography	\$0 copay; 1 per year; age 40+	\$0 copay; age 40+	\$0 copay	\$0 copay	40%; no deductible
Outpatient Surgery	\$150 copay with referral	\$150 copay with referral	10% after deductible	20% after deductible	40% after deductible
Laboratory	\$0 copay with referral	\$0 copay with referral	\$0 copay	\$0 copay	40% after deductible
X-rays/ Radiology	\$30 copay (routine); \$60 copay (complex) with referral	\$30 copay (routine); \$60 copay (complex) with referral	10% after deductible	20% after deductible	40% after deductible

Plan Name	Aetna HMO*	Keystone/ AmeriHealth HMO*	PennCare/ Personal Choice*		
	HMO Providers	HMO Providers	PennCare Providers	Personal Choice Providers	Non-Preferred Providers
Emergency Room	\$150 copay (waived if admitted)	\$150 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)	\$100 copay (waived if admitted)
Ambulance	\$0 copay	\$0 copay	\$0 copay; non-emergency: 10% after deductible	\$0 copay; non-emergency: 20% after deductible	\$0 copay; non-emergency: 40% after deductible
Durable Medical Equipment	\$0 copay if medically necessary; pre-approval recommended	\$0 copay if medically necessary; pre-approval recommended	Provider not available	20% after deductible	40% after deductible
Skilled Nursing Facility	\$350 copay per admission with primary referral & review by case mgmt; limit of 100 days/calendar year	\$0 copay; limit of 180 days/ calendar year	10% after deductible, limit of 120 days/ plan year	20%, after deductible; limit of 120 days/ plan year	40% after deductible; limit of 120 days/ plan year
Home Health Care	\$0 copay with coordination by patient mgmt dept	\$0 copay; subject to medical necessity	10% after deductible	20% after deductible	40% after deductible
Mental Health / Substance Abuse Network	Aetna HMO providers	Keystone/ AmeriHealth HMO providers	Penn Behavioral Health Staff	Penn Behavioral Health Regional Network	Any qualified provider
Mental Health / Substance Abuse Inpatient	\$350 copay per admission with referral; unlimited days if medically necessary	\$350 copay per admission with referral; unlimited days if medically necessary	10% after deductible; unlimited days if medically necessary	10% after \$100 indiv/\$300 fam deductible; unlimited days if med. necessary	40% after deductible; unlimited days if medically necessary
Mental Health / Substance Abuse Outpatient	\$35 copay per visit; unlimited visits if medically necessary	\$25 copay per visit; unlimited visits if medically necessary	\$20 copay per visit; unlimited visits if medically necessary	\$20 copay per visit; unlimited visits if medically necessary	40% after deductible; unlimited visits if medically necessary

* Pre-certification needed for certain services.

** \$35 allowed for contacts or prescription eyeglasses every two years. See member handbook for vision exam benefits schedule.

Legal Disclaimer: This comparison chart provides a brief summary of the key benefits provided through the University of Pennsylvania Health Plan. More details about the Plan can be found in governing Plan documents. In the event of a discrepancy between the applicable Plan documents and this chart, the relevant Plan documents govern. This chart describes the benefits currently available through the Plan; the University reserves the right to modify, amend, or terminate the Plan or any benefits provided through the Plan at any time and for any reason.