

Temple University Student Health Insurance
Medical/Podiatric School Students
Plan Options 2010-2011

Service	Keystone POS High Option Referred Care	Keystone POS Self-Referral Care	Keystone POS Low Option Referred Care	Keystone POS Self-Referral Care	Flex Personal Choice In-Network	Personal Choice Out-of-Network	Basic Personal Choice In-Network	Personal Choice Out of Network	
Deductible	Individual Family	\$0 \$0	\$500 \$1,500	\$0 \$0	\$1,500 \$4,500	\$0 \$0	\$1,500 \$4,500	\$500 \$1,000	\$1,000 \$2,000
Out-of-Pocket Maximum	Individual Family	None None	\$3,000 \$6,000	None None	\$10,000 \$30,000	None None	\$10,000 \$30,000	\$3,000 \$6,000	\$6,000 \$12,000
Lifetime Maximum		Unlimited	\$1,000,000	Unlimited	\$500,000	Unlimited	\$500,000	\$1,000,000	\$1,000,000
Office Visit Fees							\$10 copay, 4 visits/year, (primary and speciality care combined); thereafter visits are covered 75%, after deductible		
	Primary Care Services Specialist Services Pediatric Immunization Routine GYN Exam Mammogram	\$10 co-payment \$15 co-payment 100% \$15 co-payment 100%	70% after deductible 70% after deductible 70% no deductible 70% no deductible 70% no deductible	\$20 co-payment \$40 co-payment 100% \$20 co-payment 100%	50% after deductible 50% after deductible 50% no deductible 50% no deductible 50% no deductible	\$15 co-payment \$30 co-payment 100% \$15 co-payment 100%	50% after deductible 50% after deductible 50% no deductible 50% no deductible 50% no deductible	50% after deductible 50% after deductible 100%, no deductible 100%, no deductible 60%, no deductible	50% after deductible 50% after deductible 50%, no deductible 50%, no deductible 50%, no deductible
Outpatient Laboratory/Pathology		100%	70% after deductible	100%	50% after deductible	100%	50% after deductible	50% after deductible	50% after deductible
Maternity	First OB Visit Hospital	\$15 co-payment \$240 co-payment per admission	70% after deductible 70% after deductible	\$20 co-payment \$250/day; max of 5 copays/admission	50% after deductible 50% after deductible	\$15 co-payment \$100/day; maximum of 5 co-pays/Admission	50% after deductible 50% after deductible	75% after deductible 75% after deductible	50% after deductible 50% after deductible
Hospital Coverage	Inpatient Hospital Services Inpatient Hospital Days Outpatient Surgery	\$240 co-payment per admission Unlimited \$100 co-payment	70% after deductible 120 Days 70% after deductible	\$250/day; max of 5 copays/admission Unlimited \$125 co-payment	50% after deductible 70 Days 50% after deductible	\$100/day; maximum of 5 co-pays/admission Unlimited \$50 co-payment	50% after deductible 70 Days 50% after deductible	75% after deductible 70 Days 75% after deductible	50% after deductible 70 Days 50% after deductible
Emergency Room		\$35 co-payment (waived if admitted)	\$35 co-payment (waived if admitted)	\$100 co-payment (not waived if admitted)	\$100 co-payment (waived if admitted)	\$100 co-payment (waived if admitted)	\$100 co-payment (waived if admitted)	75% after deductible	75% after deductible
Ambulance		100%	70% after deductible	100%	50% after deductible	100%	50% after deductible	100% after deductible	50% after deductible
Outpatient X-Ray/Radiology	Routine Radiology/Diagnostic MRI,CT/CTA scan, PET scan	100% 100%	70% after deductible 70% after deductible	\$40 co-payment \$80 co-payment	50% after deductible 50% after deductible	\$30 co-payment \$60 co-payment	50% after deductible 50% after deductible	50% after deductible 50% after deductible	50% after deductible 50% after deductible
Therapy Services	Physical and Occupational Cardiac Rehabilitation Pulmonary Rehabilitation Speech Spinal Manipulations	100% up to 60 consecutive days/condition 100% up to 60 consecutive days/condition 100% up to 60 consecutive days/condition 100% up to 60 consecutive days/condition	70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after deductible	\$40 co-payment 30 visits per calendar year \$40 co-payment 36 visits per calendar year \$40 co-payment 36 visits per calendar year \$40 co-payment 20 visits per calendar year \$40 co-payment 20 visits per calendar year	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible	\$30 co-payment 30 visits per calendar year \$30 co-payment 36 visits per calendar year \$30 co-payment 36 visits per calendar year \$30 co-payment 20 visits per calendar year \$30 co-payment 20 visits per calendar year	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible	75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max) 75% after deductible (Up to an aggregate \$1000 max)	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
Injectable Medications	Standard Injectables BioTech/Speciality Injectables Chemo/Radiation/Dialysis	100% 100% 100%	70% after deductible 70% after deductible 70% after deductible	100% \$100 co-payment 100%	50% after deductible 50% after deductible 50% after deductible	100% \$75 co-payment 100%	50% after deductible 50% after deductible 50% after deductible	75% after deductible 75% after deductible 75% after deductible	50% after deductible 50% after deductible 50% after deductible

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Outpatient Private Duty Nursing Skilled Nursing Facility	100% 100% (up to 180 Days)	70% after deductible 70% after deductible (up to 240 days)	85% \$125/day; max of 5 copays/admission (up to 120 days per calendar year)	50% after deductible 50% after deductible (60 days per calendar year)	90% (360 hours per calendar year) \$50/day; maximum of 5 co-payments/admission (120 days per calendar year)	50% after deductible 50% after deductible	75%, after deductible (100 hours per calendar year) 75%, after deductible (30 days per calendar year)	50%, after deductible 50%, after deductible
Hospice and Home Health Care	100%	70% after deductible	100%	50% after deductible	100%	50% after deductible	75%, after deductible	50%, after deductible
Durable Medical Equipment	100%	70% after deductible	50%	50% after deductible (\$2500 benefit max per calendar year) 50% after deductible	70%	50% after deductible (\$2500 benefit max per calendar year) 50% after deductible	75%, after deductible	50%, after deductible
Prosthetic	100%	70% after deductible	50%	50% after deductible 50% after deductible	70%	50% after deductible 50% after deductible	75%, after deductible	50%, after deductible
Mental Health Care								
Outpatient	\$15 co-payment	70% after deductible	\$40 co-payment	50% after deductible	\$30 co-payment	50% after deductible	\$10 copay, 4 visits/year, (primary and speciality care combined); thereafter visits are covered 75%, after deductible	50%, after deductible
Inpatient	\$240 co-pay per admission	70% after deductible	\$250/day max of 5 copays/admission	50% after deductible	\$100/day; max of 5 co-payments/admission	50% after deductible	75% after deductible	50%, after deductible
Serious Mental Illness Care								
Outpatient	\$15 co-payment	70% after deductible	\$40 co-payment	50% after deductible	\$30 co-payment	50% after deductible	\$10 copay, 4 visits/year, (primary and speciality care combined); thereafter visits are covered 75%, after deductible	50%, after deductible
Inpatient	\$240 co-pay per admission	70% after deductible	\$250/day; max of 5 copays/admission	50% after deductible	\$100/day; max of 5 co-payments/admission	50% after deductible	75% after deductible	50%, after deductible
Substance Abuse Treatment								
Outpatient/Partial Facility Visits Rehabilitation/Detoxification	\$15 co-payment	70% after deductible	\$40 co-payment	50% after deductible	\$30 co-payment	50% after deductible	\$10 copay, 4 visits/year, (primary and speciality care combined); thereafter visits are covered 75%, after deductible	50%, after deductible
Inpatient Rehabilitation	\$240 co-pay per admission	70% after deductible	\$250/day; max of 5 copays/admission	50% after deductible	\$100/day; max of 5 co-payments/admission	50% after deductible	75% after deductible	50%, after deductible
Inpatient Detoxification	\$240 co-pay per admission	70% after deductible	\$250/day; max of 5 copays/admission	50% after deductible	\$100/day; max of 5 co-payments/admission	50% after deductible	75% after deductible	50%, after deductible
Prescription Drugs	\$15/\$20	Not covered; except in emergency situations	\$15/\$35/\$50	30% of drugs retail cost for the total amount dispensed	\$10/\$20/\$50	30% of drugs retail cost for the total amount dispensed	\$15/\$35/\$50	30% of drugs retail cost for the total amount dispensed
Dental Rider								
Dental Visits	\$5 co-payment	70% after deductible	\$5 co-payment	70% after deductible	Not Available	Not Available	Not Available	Not Available
Oral Examination & Diagnosis	Once every six months		Once every six months					
Prophylaxis (Cleaning)	Once every six months		Once every six months					
Topical Fluoride Application	Limited to children to age 19 every six months		Limited to children to age 19 every six months					
Vision Rider								
Vision Examination	\$15 co-payment once every 2 calendar years	70% after deductible	\$40 co-payment once every 2 calendar years	70% after deductible	Not Available	Not Available	Not Available	Not Available
Prescription Lenses and Frames	Standard lenses and frames (participating provider) \$35 reimbursement (non-participating provider)	70% after deductible	Standard lenses and frames (participating provider) \$35 reimbursement (non-participating provider)	70% after deductible	Not Available	Not Available	Not Available	Not Available

* Dental and Vision rider only available with Keystone POS