School District of Philadelphia
April 2020
Benefit Comparison Keystone HMO 20 - Personal Choice 25/35/50

	Keystone HMO 20	Personal Choice 25/35/50	
	In Network (Referred Only)*	**In Network**	**Out of Network**
Benefits per Calendar Year			
Deductible (Embedded) - Individual / Family [1]	$0 / $0	$0 / $0	$2,000 / $6,000
Out-of-Pocket Maximum (Embedded) - Individual / Family [2]	$1,000 / $2,000	$1,000 / $2,000	$3,000 / $6,000
Coinsurance	0%	0%	50%
Coinsurance Limit - Individual / Family	N/A	N/A	N/A
Preventive Services			
Preventive Care	No Charge	No Charge	50% no deductible
Colonoscopy: Preventive Plus Providers	No Charge	No Charge	Not Covered
Colonoscopy: Hospital Based	No Charge	No Charge	50% no deductible
Physician Services			
PCP Office Visit	$20 Copay	$25 Copay	50% after deductible
Specialist Visit	$30 Copay	$35 Copay	50% after deductible
Retail Health Clinic Visit	$20 Copay	$25 Copay	50% after deductible
Telemedicine	No Charge	No Charge	Not Covered
Urgent Care	$30 Copay	$35 Copay	50% after deductible
Therapy Services			
Physical Therapy (60 visits/year) Freestanding & Hospital Based[3]	No Charge	Visits 1-30: $20 Copay ; Visits 31+: No Charge	50% after deductible
Occupational Therapy (60 visits/year) Freestanding & Hospital Based [3]	No Charge	Visits 1-30: $20 Copay ; Visits 31+: No Charge	50% after deductible
Speech Therapy (60 visits/year)[3]	No Charge	Visits 1-30: $20 Copay ; Visits 31+: $30 Copay	50% after deductible
Emergency Services			
Emergency Room (copay waived if admitted)	$100 Copay	$100 Copay	Covered at In-Network level
Emergency Ambulance	No Charge	No Charge	Covered at In-Network level
Non-Emergency Ambulance	No Charge	No Charge	50% after Deductible
Hospital Services			
Inpatient Hospital Services (IN:365 days/year; OON: 70 days/year)	No Charge	No Charge	50% after deductible
Maternity Hospital Services [5]	No Charge	No Charge	50% after deductible
Inpatient Professional Services (includes Maternity)	No Charge	No Charge	50% after deductible
Outpatient Surgery			
Freestanding and Hospital Based	No Charge	No Charge	50% after deductible
Outpatient Professional Services	No Charge	No Charge	50% after deductible
Outpatient Diagnostics			
Diagnostic Medical (EKG)	No Charge	$30 Copay	50% after deductible
Routine Radiology (X-ray) Freestanding & Hospital Based	No Charge	$30 Copay	50% after deductible
Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan) Freestanding & Hospital Based	No Charge	$30 Copay	50% after deductible
Outpatient Lab & Pathology - Freestanding & Hospital Based	No Charge	No Charge	50% after deductible

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Other Medical Services			
Acupuncture (18 visits/year)	$30 Copay	$35 Copay	50% after deductible
Spinal Manipulations (30 visits/year) [4]	No Charge	$30 Copay	50% after deductible
Standard Injectable	No Charge	No Charge	50% after deductible
Allergy Injections	No Charge	No Charge	50% after deductible
Biotech/Specialty Injectable	No Charge	No Charge	50% after deductible
Self-Administered Prescription Drugs [6]	No Charge	No Charge	50% after deductible
Chemotherapy	No Charge	No Charge	50% after deductible
Dialysis	No Charge	No Charge	50% after deductible
Skilled Nursing Facility [4]	No Charge (180 days year)	No Charge (120 days year)	50% after deductible
Home Health	No Charge	No Charge	50% after deductible
Hospice	No Charge	No Charge	50% after deductible
Durable Medical Equipment (DME)	No Charge	$30 Copay	50% after deductible
Mental Health Outpatient (includes serious mental illness and substance abuse)	$25 Copay	$30 Copay	50% after deductible
Mental Health Inpatient (includes serious mental illness and substance abuse) [5]	No Charge	No Charge	50% after deductible
Routine Eye Care	$25 Copay	N/A	N/A

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Contractual Rate Salary Contribution **PFT Salary Contribution is 1.5%**	**Contractual Salary Contribution**	**Grandfathered - Personal Choice 3% Contribution in addition to Salary Contribution**	**Personal Choice 5% Contribution in addition to Salary Contribution**
Single	$0.00	$8.88	$14.80
Employee & Child	$0.00	$12.43	$20.72
Employee & Children	$0.00	$15.98	$26.64
Employee & Spouse or Life Partner	$0.00	$17.76	$29.60
Employee & Spouse or Life Partner with Surcharge **PFT surcharge $75 per month ($34.62 per pay)** **SPAP surcharge $50 per month ($23.08 per pay) until 9/1/20**	$34.62	$52.38	$64.22
Family	$0.00	$26.64	$44.40
Family with Spouse or Life Partner with Surcharge **PFT surcharge $75 per month($34.62 per pay)** **SPAP surcharge $50 per month ($23.08 per pay) until 9/1/20**	$34.62	$61.26	$79.02

Keystone HMO is a managed care program. Coverage is available when your care is provide or referred by a Keystone primary care physician (PCP). You Keystone PCP may also refer you to other Keystone providers for care if needed.

[1]Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits (Personal Choice).

[2]Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.

[3]Physical Therapy, Occupational Therapy, and Speech Therapy combined visit limit in and out-of-network (Personal Choice).

[4] Combined in and out of network (Personal Choice).

[5]Inpatient Hospital out of network day limit combined for al inpatient medical, maternity, mental health, serious mental illness, and substance abuses services (Personal Choice).

[6] To obtain a list of Self-Administered Prescription Drugs, please logon to *https://www.ibx.com/individuals/member_resources/specialty_drug/index.html* and then click on *Self-Administered Drug List.*