Independence Drexel University

Coverage for: FAMILY | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Referred Provider $0 person / $0 family; for Self-Referred Provider $500 person / $1,500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		a Drexel University Provider	a Referred Provider	a Self-Referred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copayment (copay)/visit	$20 copay/visit	30%	None
	Specialist visit	$10 copay/visit	$40 copay/visit	30%	PCP referral required.
	Preventive care/screening/immunization	Covered at No Charge	Covered at No Charge	30%, Deductible does not apply	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	$20 copay/test(X-Ray)/No Charge(Blood Work)	30%	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	No Charge	$80 copay/test	30%	PCP referral required. Pre-certification required for certain services. *See section General Information.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/preapproval	Generic drugs	Not Covered	Not Covered	Not Covered	None
	Preferred brand	Not Covered	Not Covered	Not Covered	None
	Non-preferred drugs	Not Covered	Not Covered	Not Covered	None
	Specialty drugs	$100 copay/prescription fill	$100 copay/prescription fill	30%	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self administered specialty drugs follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$50 copay/visit	30%	Pre-certification may be required. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network.
	Physician/surgeon fees	No Charge	No Charge	30%	Pre-certification may be required. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Covered at in-network level	None

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		a Drexel University Provider	a Referred Provider	a Self-Referred Provider	
	Emergency medical transportation	No Charge	No Charge	Covered at in-network level	None
	Urgent care	Covered No Charge at St. Chris Pediatric Urgent Care	$35 copay/visit	30%	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$240 copay per admission	$100/day; Maximum (max) of 5 copay/admission	30%	Pre-certification required. There is a $700 Penalty for failure to pre-authorize Inpatient services or treatment out-of-network.
	Physician/surgeon fees	No Charge	No Charge	30%	Pre-certification required. There is a $700 Penalty for failure to pre-authorize Inpatient services or treatment out-of-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	$40 copay/visit	30%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network.
	Inpatient services	Not Covered	$100/day; max of 5 copay/admission	30%	Pre-certification required. There is a $700 Penalty for failure to pre-authorize Inpatient services or treatment out-of-network.
If you are pregnant	Office visits	$10 copay/visit	$20 copay/visit	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	No Charge	No Charge	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery facility services	$240 copay per admission	$100/day; max of 5 copay/admission	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
If you need help	Home health care	No Charge	No Charge	30%	Pre-certification required. 20% reduction in

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		a Drexel University Provider	a Referred Provider	a Self-Referred Provider	
recovering or have other special health needs					benefits for failure to pre-authorize out-of-network outpatient services or treatment.
	Rehabilitation services	No Charge	$20 copay/visit; 30 visits per calendar year	30% 30 visits per calendar year	PCP referral required. Pre-authorization required for Speech Therapy.
	Habilitation services	No Charge	$20 copay/visit; 30 visits per calendar year	30% 30 visits per calendar year	PCP referral required. Pre-authorization required for Speech Therapy.
	Skilled nursing care	Not Covered	$50/day; max of 5 copay/admission 120 days per calendar year	30% 60 days per calendar year	Pre-certification required. There is a $700 penalty for failure to pre-authorize Inpatient services or treatment out-of-network. 60 visits/ benefit period.
	Durable medical equipment	Not Covered	Covered 30%	50%	Pre-certification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert out-of-network.
	Hospice services	No Charge	No Charge	30%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private-duty nursing
- Routine Eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY:711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan . For more information about your rights, this notice, or assistance, contact: Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$240
Other coinsurance	100%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	**$0**
Copayments	**$200**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$50**
The total Peg would pay is	**$50**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$240
Other coinsurance	100%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	**$0**
Copayments	**$20**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$6,000**
The total Joe would pay is	**$6,000**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$240
Other coinsurance	100%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	**$0**
Copayments	**$20**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$70**
The total Mia would pay is	**$70**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.