AmeriHealth

Medical Benefit Highlights

Drexel University PHO AH-PA Point-of-Service

Covered Services	Your Costs (You pay)		
Benefits per Calendar Year	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Deductible (Embedded)[1]			
Individual/Family	$0/$0		$500/$1,500
Out-of-Pocket Maximum (Embedded)[2]			
Individual/Family	$1,500/$3,000	$2,000/$4,000	$3,000/$9,000
Coinsurance	0%	0%	30%
Total Maximum Out-of-Pocket (Embedded)[2] Individual/Family	$2,000/$4,000	$2,000/$4,000	$3,000/$9,000
Preventive Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Preventive Care	No charge	No charge	30% no deductible
Preventive Colonoscopy			
Preventive Plus Providers	No charge	No charge	Not covered
Hospital Based	No charge	No charge	30% no deductible
Physician Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Primary Care Physician (PCP)			
Office Visit	No charge	$20	30% after deductible
Telemedicine Visit	No charge	$20	30% after deductible
Specialist			
Office Visit	$10	$40	30% after deductible
Telemedicine Visit	$10	$40	30% after deductible
Retail Health Clinic Visit	No charge	$20	30% after deductible
Urgent Care Visit	No charge	$35	30% after deductible
Virtual Care[3]	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Telemedicine	No charge	No charge	Not covered
Teledermatology	No charge	No charge	Not covered
Telebehavioral Health	No charge	No charge	Not covered
Therapy Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Physical Therapy (Referred: 30 visits/year; Self-Referred: 30 visits/year)[4]			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Occupational Therapy (Referred: 30 visits/year; Self-Referred: 30 visits/year)[4]			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Speech Therapy (Referred: 20 visits/year; Self-Referred: 20 visits/year)	No charge	$20	30% after deductible
Emergency Services	**In-Network Tier 1**	**In-Network Tier 2**	**Self-Referred**
Emergency Room (copay waived if admitted)	$100	$100	Covered at In-Network level
Emergency Ambulance	No charge	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	No charge	30% after deductible

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Hospital Services	In-Network Tier 1	In-Network Tier 2	Self-Referred
Inpatient Hospital Services (Referred: 365 days/year; Self-Referred: 70 days/year)[5]	$240/Admission	$100/Day; max of 5 copays per admission	30% after deductible
Observation Services	$100	$100	30% after deductible
Maternity Hospital Services[5]	$240/Admission	$100/Day; max of 5 copays per admission	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	No charge	30% after deductible

Outpatient Surgery	In-Network Tier 1	In-Network Tier 2	Self-Referred
Freestanding	No charge	$50	30% after deductible
Hospital Based	No charge	$50	30% after deductible
Outpatient Professional Services	No charge	No charge	30% after deductible

Outpatient Diagnostics	In-Network Tier 1	In-Network Tier 2	Self-Referred
Diagnostic Medical (EKG)	No charge	$20	30% after deductible
Routine Radiology (X-Ray)			
Freestanding	No charge	$20	30% after deductible
Hospital Based	No charge	$20	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)			
Freestanding	No charge	$80	30% after deductible
Hospital Based	No charge	$80	30% after deductible

Outpatient Lab and Pathology	In-Network Tier 1	In-Network Tier 2	Self-Referred
Freestanding	No charge	No charge	30% after deductible
Hospital Based	No charge	No charge	30% after deductible

Other Medical Services	In-Network Tier 1	In-Network Tier 2	Self-Referred
Spinal Manipulations (Referred: 20 visits/year; Self-Referred: 20 visits/year)	Not covered	$20	30% after deductible
Acupuncture (Referred: 18 visits/year; Self-Referred: 18 visits/year)	$10	$40	30% after deductible
Standard Injectables	No charge	$20	30% after deductible
Allergy Injections	No charge	$20	30% after deductible
Biotech/Specialty Injectables			
Home/Office	$100	$100	30% after deductible
Outpatient	$100	$100	30% after deductible
Chemotherapy	No charge	No charge	30% after deductible
Dialysis	No charge	No charge	30% after deductible
Skilled Nursing Facility (Referred: 120 days/year; Self-Referred: 60 days/year)	Not covered	$50/Day; max of 5 copays per admission	30% after deductible
Home Health	No charge	No charge	30% after deductible
Hospice	No charge	No charge	30% after deductible
Durable Medical Equipment (DME)	Not covered	30%	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)			
Office Visit	Not covered	$20	30% after deductible
All Other Services	Not covered	$20	30% after deductible
Mental Health – Inpatient (includes serious	Not covered	$100/Day; max of 5	30% after deductible

mental illness and substance abuse)[5]		copays per admission	

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.

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 Telemedicine is provided by a designated telemedicine provider, please visit **www.amerihealth.com/findcarenow**.

4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

5 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

AmeriHealth Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). You have the freedom to self-refer your care either to an AmeriHealth participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.
Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their AmeriHealth members. You can view the sites selected by your PCP at **www.amerihealth.com**.

This summary represents only a partial listing of benefits and exclusions of the Medical Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.amerihealth.com/LGBooklet** or call **1-800-275-2583** (TTY: 711).

Benefits may be changed by AmeriHealth to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.amerihealth.com/preapproval** or call the phone number that is listed on the back of your identification card.

are underwritten or administered by AmeriHealth HMO, Inc. **www.amerihealth.com**

Independence

Drug Benefit Highlights

Drexel University POS Rx $10/$30/$50

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	$0/$0
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Formulary[1]	Premium	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$10	30% Reimbursement
Tier 2 Preferred Brand	$30	30% Reimbursement
Tier 3 Non-Preferred Drugs	$50	30% Reimbursement
Dispensing Limits	30 day supply max	30 day supply max
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$20	Not covered
Tier 2 Preferred Brand Drugs	$60	Not covered
Tier 3 Non-Preferred Drugs	$100	Not covered
Dispensing Limits[2]	90 day supply max	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[3]	Covered	Covered
Compound Medications	Covered	Covered
Contraceptives	Covered	Covered
Diabetic Supplies (i.e., test strips)	Covered	Covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Weight Control Drugs	Covered	Covered
Allergy Serum	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered

Independence

1 Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto **www.ibx.com**.

2 Up to a 90-day supply of drugs to treat chronic conditions available at any participating retail pharmacy or mail for same cost share.

3 Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by pharmacy policy. As a result, this program may not cover all of your health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered.

All covered self-administered specialty medications will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.

The pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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*.