

# Medical Benefit Highlights

## Drexel University PHO HSA-Qualified CDHP

Covered Services	Your Costs (You pay)		
	In-Network Tier 1	In-Network Tier 2	Out-of-Network
<b>Benefits per Calendar Year</b>			
Deductible (Aggregate) <sup>1</sup> Individual/Family	\$1,600/\$3,200	\$2,000/\$4,000	\$5,000/\$10,000
Out-of-Pocket Maximum (See Footnote) <sup>2</sup> Individual/Family	\$6,450/\$12,900		\$10,000/\$20,000
Coinsurance	0%	20%	50%
<b>Preventive Services</b>	<b>In-Network Tier 1</b>	<b>In-Network Tier 2</b>	<b>Out-of-Network</b>
Preventive Care	No charge no deductible	No charge no deductible	50% no deductible
Preventive Colonoscopy			
Preventive Plus Providers	No charge no deductible	No charge no deductible	Not covered
Hospital Based	No charge no deductible	No charge no deductible	50% no deductible
<b>Physician Services</b>	<b>In-Network Tier 1</b>	<b>In-Network Tier 2</b>	<b>Out-of-Network</b>
Primary Care Physician (PCP)			
Office Visit	No charge after deductible	20% after deductible	50% after deductible
Telemedicine Visit	No charge after deductible	20% after deductible	50% after deductible
Specialist			
Office Visit	No charge after deductible	20% after deductible	50% after deductible
Telemedicine Visit	No charge after deductible	20% after deductible	50% after deductible
Retail Health Clinic Visit	No charge after deductible	20% after deductible	50% after deductible
Urgent Care Visit	No charge after deductible	20% after deductible	50% after deductible
<b>Virtual Care<sup>3</sup></b>	<b>In-Network Tier 1</b>	<b>In-Network Tier 2</b>	<b>Out-of-Network</b>
Telemedicine	No charge after deductible	No charge after deductible	Not covered
Teledermatology	No charge after deductible	No charge after deductible	Not covered
Telebehavioral Health	No charge after deductible	No charge after deductible	Not covered

<b>Therapy Services</b>	<b>In-Network Tier 1</b>	<b>In-Network Tier 2</b>	<b>Out-of-Network</b>
<b>Physical Therapy (30 visits/year)<sup>4</sup></b>			
Freestanding	No charge after deductible	20% after deductible	50% after deductible
Hospital Based	No charge after deductible	20% after deductible	50% after deductible
<b>Occupational Therapy (30 visits/year)<sup>4</sup></b>			
Freestanding	No charge after deductible	20% after deductible	50% after deductible
Hospital Based	No charge after deductible	20% after deductible	50% after deductible
<b>Speech Therapy (20 visits/year)<sup>5</sup></b>	No charge after deductible	20% after deductible	50% after deductible
<b>Emergency Services</b>			
<b>Emergency Room</b>	No charge after deductible	No charge after deductible	Covered at In-Network level
<b>Emergency Ambulance</b>	No charge after deductible	No charge after deductible	Covered at In-Network level
<b>Non-Emergency Ambulance</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Hospital Services</b>			
<b>Inpatient Hospital Services (In-Network Tier 1: 365 days/year; Out-of-Network: 70 days/year)<sup>6</sup></b>	No charge after deductible	20% after deductible	50% after deductible
<b>Observation Services</b>	No charge after deductible	No charge after deductible	50% after deductible
<b>Maternity Hospital Services<sup>6</sup></b>	No charge after deductible	20% after deductible	50% after deductible
<b>Inpatient Professional Services (includes Maternity)</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>			
<b>Freestanding</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Hospital Based</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Outpatient Professional Services</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Outpatient Diagnostics</b>			
<b>Diagnostic Medical (EKG)</b>	No charge after deductible	20% after deductible	50% after deductible
<b>Routine Radiology (X-Ray)</b>	No charge after deductible	20% after deductible	50% after deductible

Freestanding	No charge after deductible	20% after deductible	50% after deductible
Hospital Based	No charge after deductible	20% after deductible	50% after deductible
<b>Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)</b>			
Freestanding	No charge after deductible	20% after deductible	50% after deductible
Hospital Based	No charge after deductible	20% after deductible	50% after deductible
<b>Outpatient Lab and Pathology</b>			
Freestanding	No charge after deductible	20% after deductible	50% after deductible
Hospital Based	No charge after deductible	20% after deductible	50% after deductible
<b>Other Medical Services</b>			
<b>In-Network Tier 1</b>			
Spinal Manipulations (20 visits/year) <sup>5</sup>	Not covered	20% after deductible	50% after deductible
Acupuncture (18 visits/year) <sup>5</sup>	No charge after deductible	20% after deductible	50% after deductible
Standard Injectables	No charge after deductible	20% after deductible	50% after deductible
Allergy Injections	No charge after deductible	20% after deductible	50% after deductible
<b>In-Network Tier 2</b>			
Biotech/Specialty Injectables			
Home/Office	No charge after deductible	20% after deductible	50% after deductible
Outpatient	No charge after deductible	20% after deductible	50% after deductible
Chemotherapy	No charge after deductible	20% after deductible	50% after deductible
Dialysis	No charge after deductible	20% after deductible	50% after deductible
Skilled Nursing Facility (120 days/year) <sup>5</sup>	Not covered	20% after deductible	50% after deductible
Home Health	No charge after deductible	20% after deductible	50% after deductible
Hospice	No charge after deductible	20% after deductible	50% after deductible
<b>Out-of-Network</b>			
Durable Medical Equipment (DME)	Not covered	20% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)			
Office Visit	Not covered	20% after deductible	50% after deductible
All Other Services	Not covered	20% after deductible	50% after deductible

Mental Health – Inpatient (includes serious mental illness and substance abuse) <sup>6</sup>	Not covered	20% after deductible	50% after deductible
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- 1 Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.
- 2 In-Network 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. Out-of-Network aggregate out-of-pocket maximum: For family coverage, the entire family out-of-pocket maximum must be met before copayments or coinsurance are applied for an individual member.
- 3 Telemedicine is provided by a designated telemedicine provider, please visit [www.ibx.com/findcarenow](http://www.ibx.com/findcarenow).
- 4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 5 Combined in and out-of-network.
- 6 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

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.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet) or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross 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.ibx.com/preapproval> or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. [www.ibx.com](http://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 કોલ 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 schwetzsch, 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'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

### Urdu:

توجه درکار ہے: 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 នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@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>.