Independence

Medical Benefit Highlights

Drexel University PHO PC-320

Covered Services	Your Costs (You pay)		
Benefits per Calendar Year	**In-Network Tier 1**	**In-Network Tier 2**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$0/$0	$300/$600	$1,000/$2,000
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$1,000/$2,000	$2,000/$4,000	$3,000/$6,000
Coinsurance	0%	10%	30%
Total Maximum Out-of-Pocket (Embedded)2 Individual/Family	$2,000/$4,000	$2,000/$4,000	$3,000/$6,000
Preventive Services	**In-Network Tier 1**	**In-Network Tier 2**	**Out-of-Network**
Preventive Care	No charge	No charge no deductible	30% no deductible
Preventive Colonoscopy			
Preventive Plus Providers	No charge	No charge no deductible	Not covered
Hospital Based	No charge	No charge no deductible	30% no deductible
Physician Services	**In-Network Tier 1**	**In-Network Tier 2**	**Out-of-Network**
Primary Care Physician (PCP)			
Office Visit	No charge	$20 no deductible	30% after deductible
Telemedicine Visit	No charge	$20 no deductible	30% after deductible
Specialist			
Office Visit	$10	$30 no deductible	30% after deductible
Telemedicine Visit	$10	$30 no deductible	30% after deductible
Retail Health Clinic Visit	No charge	$20 no deductible	30% after deductible
Urgent Care Visit	No charge	$35 no deductible	30% after deductible
Virtual Care[3]	**In-Network Tier 1**	**In-Network Tier 2**	**Out-of-Network**
Telemedicine	No charge	No charge no deductible	Not covered
Teledermatology	No charge	No charge no deductible	Not covered
Telebehavioral Health	No charge	No charge no deductible	Not covered
Therapy Services	**In-Network Tier 1**	**In-Network Tier 2**	**Out-of-Network**
Physical Therapy			
Freestanding	No charge	$30 no deductible	30% after deductible
Hospital Based	No charge	$30 no deductible	30% after deductible
Occupational Therapy			
Freestanding	No charge	$30 no deductible	30% after deductible

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Hospital Based	No charge	$30 no deductible	30% after deductible
Speech Therapy	No charge	$30 no deductible	30% after deductible

Emergency Services	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Emergency Room (copay waived if admitted)	$100	$100 no deductible	Covered at In-Network level
Emergency Ambulance	No charge	10% after deductible	10% after deductible
Non-Emergency Ambulance	No charge	10% after deductible	30% after deductible

Hospital Services	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[4]	No charge	10% after deductible	30% after deductible
Observation Services	$100	$100 no deductible	30% after deductible
Maternity Hospital Services[4]	No charge	10% after deductible	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	10% after deductible	30% after deductible

Outpatient Surgery	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Freestanding	No charge	10% after deductible	30% after deductible
Hospital Based	No charge	10% after deductible	30% after deductible
Outpatient Professional Services	No charge	10% after deductible	30% after deductible

Outpatient Diagnostics	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Diagnostic Medical (EKG)	No charge	10% after deductible	30% after deductible
Routine Radiology (X-Ray)			
Freestanding	No charge	10% after deductible	30% after deductible
Hospital Based	No charge	10% after deductible	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)			
Freestanding	No charge	10% after deductible	30% after deductible
Hospital Based	No charge	10% after deductible	30% after deductible

Outpatient Lab and Pathology	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Freestanding	No charge	No charge no deductible	30% after deductible
Hospital Based	No charge	No charge no deductible	30% after deductible

Other Medical Services	In-Network Tier 1	In-Network Tier 2	Out-of-Network
Spinal Manipulations	Not covered	$30 no deductible	30% after deductible
Acupuncture (18 visits/year)[5]	$10	$30 no deductible	30% after deductible
Standard Injectables	No charge	10% no deductible	30% after deductible
Allergy Injections	No charge	10% no deductible	30% after deductible

Biotech/Specialty Injectables			
Home/Office	No charge	No charge no deductible	30% after deductible
Outpatient	No charge	No charge no deductible	30% after deductible
Chemotherapy	No charge	10% after deductible	30% after deductible
Dialysis	No charge	10% after deductible	30% after deductible
Skilled Nursing Facility	Not covered	10% after deductible	30% after deductible
Home Health	No charge	10% after deductible	30% after deductible
Hospice	No charge	10% after deductible	30% after deductible
Durable Medical Equipment (DME)	Not covered	10% after deductible	30% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)			
Office Visit	Not covered	10% after deductible	30% after deductible
All Other Services	Not covered	10% after deductible	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[4]	Not covered	10% after deductible	30% after deductible

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.ibx.com/findcarenow**.

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

5 Combined in and out-of-network.

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** 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.

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