Independence

Medical Benefit Highlights

Drexel University CDHP HSA-Qualified

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Aggregate)[1] Individual/Family	$2,000/$4,000	$5,000/$10,000
Out-of-Pocket Maximum (See Footnote)[2] Individual/Family	$6,450/$12,900	$10,000/$20,000
Coinsurance	20%	50%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	50% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	50% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	20% after deductible	50% after deductible
Telemedicine Visit	20% after deductible	50% after deductible
Specialist		
Office Visit	20% after deductible	50% after deductible
Telemedicine Visit	20% after deductible	50% after deductible
Retail Health Clinic Visit	20% after deductible	50% after deductible
Urgent Care Visit	20% after deductible	50% after deductible
Virtual Care[3]	**In-Network**	**Out-of-Network**
Telemedicine	No charge after deductible	Not covered
Teledermatology	No charge after deductible	Not covered
Telebehavioral Health	No charge after deductible	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (30 visits/year)[4]		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Occupational Therapy (30 visits/year)[4]		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Speech Therapy (20 visits/year)[5]	20% after deductible	50% after deductible

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Emergency Services	In-Network	Out-of-Network
Emergency Room	20% after deductible	Covered at In-Network level
Emergency Ambulance	20% after deductible	Covered at In-Network level
Non-Emergency Ambulance	20% after deductible	50% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6]	20% after deductible	50% after deductible
Observation Services	20% after deductible	50% after deductible
Maternity Hospital Services[6]	20% after deductible	50% after deductible
Inpatient Professional Services (includes Maternity)	20% after deductible	50% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Outpatient Professional Services	20% after deductible	50% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	20% after deductible	50% after deductible
Routine Radiology (X-Ray)		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year)[5]	20% after deductible	50% after deductible
Acupuncture (18 visits/year)[5]	20% after deductible	50% after deductible
Standard Injectables	20% after deductible	50% after deductible
Allergy Injections	20% after deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Chemotherapy	20% after deductible	50% after deductible
Dialysis	20% after deductible	50% after deductible

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Skilled Nursing Facility (120 days/year)[5]	20% after deductible	50% after deductible
Home Health	20% after deductible	50% after deductible
Hospice	20% after deductible	50% after deductible
Durable Medical Equipment (DME)	20% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	20% after deductible	50% after deductible
All Other Services	20% after deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	20% after deductible	50% after deductible

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.

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 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

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Drug Benefit Highlights

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

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	Medical deductible applies.	Medical deductible applies.
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 after deductible	30% Reimbursement after deductible
Tier 2 Preferred Brand Drugs	$30 after deductible	30% Reimbursement after deductible
Tier 3 Non-Preferred Drugs	$50 after deductible	30% Reimbursement after deductible
Dispensing Limits[2]	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 after deductible	Not covered
Tier 2 Preferred Brand Drugs	$60 after deductible	Not covered
Tier 3 Non-Preferred Drugs	$100 after deductible	Not covered
Dispensing Limits	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 after deductible)	Covered	Covered
Injectable Fertility Drugs	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies after deductible)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Allergy Serum	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered

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Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

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).

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

Your program includes the HDHP Preventive Enhancement benefit for a defined list of drugs. For the drugs on the preventive drug list, the deductible does not apply and you are only responsible for paying the copayment or coinsurance.

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.

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.

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