



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet) or by calling 1-800-ASK-BLUE (for medical benefits) or (for prescription drug benefits) at <https://www.express-scripts.com> or by calling Express Scripts at 1-800-864-1140.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	\$0/person, \$0/family for Drexel Preferred providers; \$300/person, \$600/family for participating providers; \$1,000/person, \$2,000/family for non-participating providers.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). <b>See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</b>
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes: \$1,000/person, \$2,000/family for Drexel Preferred; \$2,000/person, \$4,000/family for participating medical providers; \$3,000/person, \$6,000/family for non-participating medical providers. For prescription drugs: \$2,000/person, \$4,000/family.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, penalties for failure to obtain preauthorization, and health care or charges this plan doesn't cover.	Even though you pay these expenses, they don't count toward any <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <b>specific</b> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of participating medical providers, see <a href="http://www.IBX.com">www.IBX.com</a> or call 1-800-ASK-BLUE.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No. A referral is not required to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Drexel Preferred or Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment (\$0 copayment for Drexel Preferred)	30% coinsurance	_____none_____
	Specialist visit	\$30 copayment (\$10 copayment for Drexel Preferred)	30% coinsurance	_____none_____
	Other practitioner office visit	\$30 copayment for chiropractor	30% coinsurance	_____none_____
	Preventive care/screening/immunization	No cost	30% coinsurance (no deductible)	One routine physical exam/year for adults. Other age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Blood work: no cost; X-ray: 10% coinsurance (No cost for Drexel Preferred)	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	10% coinsurance (No cost for Drexel Preferred)	30% coinsurance	Precertification is required.

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# Drexel University: Independence Blue Cross PPO Basic Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Drexel Preferred or Participating Provider	Non-Participating Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	Generic drugs	<b>Retail:</b> \$10 copayment (per 30-day supply); <b>Mail:</b> \$20 copayment		Covers up to a 30-day supply (retail) and a 90-day supply (mail order). For a list of participating retail pharmacies, go to <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-864-1140. Contact Express Scripts if you intend to use a non-participating pharmacy.
	Preferred brand drugs	<b>Retail:</b> \$30 copayment (per 30-day supply); <b>Mail:</b> \$60 copayment		
	Non-preferred brand drugs	<b>Retail:</b> \$50 copayment (per 30-day supply); <b>Mail:</b> \$100 copayment		<b>Note:</b> Step Therapy and prior authorization (PA) may be required. A complete list of drugs requiring PA is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .
	Specialty drugs	Coverage/cost varies based on place of setting		Specialty drugs may not be available at a retail pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	Precertification is required; penalty may apply for non-compliance.
	Physician/surgeon fees	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	\$100 copayment for true emergency		Non-emergent use of emergency room is not covered.
	Emergency medical transportation	10% coinsurance (No cost for Drexel Preferred.)	10% coinsurance	—————none—————
	Urgent care	\$35 copayment (No cost at St. Christopher Pediatric Urgent Care.)	30% coinsurance	Your costs for urgent care may vary depending on place of service.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance (No cost for Drexel Preferred)	30% coinsurance	Precertification is required; penalty may apply for non-compliance.
	Physician/surgeon fee	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	—————none—————

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Drexel Preferred or Participating Provider	Non-Participating Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient (OP) services	\$30 copayment	30% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	Precertification is required; penalty may apply for non-compliance.
	Substance use disorder outpatient (OP) services	\$30 copayment	30% coinsurance	—————none—————
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	Precertification is required; penalty may apply for non-compliance.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20 copayment (\$10 for Drexel Preferred) for first office visit only	30% coinsurance	Copayments, deductibles and/or coinsurance may apply to services other than an office visit.
	Delivery and all inpatient services	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	Precertification is requested.
<b>If you need help recovering or have other special health needs</b>	Home health care	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	Precertification is required.
	Rehabilitation services	\$30 copayment (\$0 for Drexel Preferred for speech therapy)	30% coinsurance	Physical therapy, occupational therapy
	Habilitation services			
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification is required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification required.
	Hospice service	10% coinsurance (No cost for Drexel Preferred.)	30% coinsurance	Precertification required.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	Please refer to the vision plan coverage.
	Glasses	Not covered	Not covered	Please refer to the vision plan coverage.
	Dental check-up	Not covered	Not covered	Please refer to the dental plan coverage.

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## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility treatment (AI, IVF, GIFT, ZIFT)</li><li>• Long-term care</li><li>• Non-emergency care when outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Routine eye care</li><li>• Weight loss programs</li></ul>
Other Covered Services (This isn't a complete list. Check your policy/plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (outpatient only)</li></ul>

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-ASK-BLUE. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

**Medical:** Independence Blue Cross at 1-800-ASK-BLUE.

**Prescriptions:** Express Scripts at 1-800-864-1140.

**Department of Labor,** Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Pennsylvania Department of Insurance:** The consumer assistance program can help you file an appeal. For the consumer assistance program you can contact 1-877-881-6388 or [www.insurance.pa.gov](http://www.insurance.pa.gov).

**Questions:** For medical, call 1-800-ASK-BLUE or visit [www.IBX.com](http://www.IBX.com). For prescriptions, call 1-800-864-1140 or visit [www.express-scripts.com](http://www.express-scripts.com).

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## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-355-2583.	如果需要中文的帮助, 请拨打这个号码 1-800-355-2583.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-355-2583.	Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-355-2583.

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



## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,485
- Patient pays \$55

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copayments	\$25
Coinsurance	\$0
Limits or exclusions	\$30
<b>Total</b>	<b>\$55</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,540
- Patient pays \$860

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$300
Copayments	\$420
Coinsurance	\$100
Limits or exclusions	\$40
<b>Total</b>	<b>\$860</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.