Drexel University: Independence Blue Cross High Deductible 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:** HDHP

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 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 deductible?	**$1,500**/person, **$3,000**/family for Drexel Preferred providers; **$2,000**/person, **$4,000**/family for participating providers; **$5,000**/person, **$10,000**/ family for non-participating providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). **See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.**
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes: $6,450**/person, **$12,900**/family for Drexel Preferred, participating medical providers, and prescription drugs; **$10,000**/person, **$20,000** / family for non-participating medical providers	The **out-of-pocket limit** 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 out–of–pocket limit?	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 **out-of-pocket limit.**
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 **specific** covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of participating medical providers, see www.IBX.com or call 1-800-ASK-BLUE.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**No.** A referral is not required to see a specialist.	You can see the **specialist** 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 **excluded services.**

Questions: For medical, call 1-800-ASK-BLUE or visit www.IBX.com. For prescriptions, call 1-800-864-1140 or visit www.express-scripts.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-ASK-BLUE to request a copy.

- **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% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	————————none————————
	Specialist visit			————————none————————
	Other practitioner office visit	20% coinsurance	50% coinsurance	20 visit maximum/calendar year for spinal manipulation combined In and Out
	Preventive care/screening/ immunization	No cost	50% 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)	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your cost if you use a Drexel Preferred or Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	**Retail:** $10 copayment (per 30-day supply), after deductible **Mail:** $20 copayment, after deductible		Covers up to a 30-day supply (retail) and a 90-day supply (mail order). For a list of participating retail pharmacies, go to www.express-scripts.com or call 1-800-864-1140. Contact Express Scripts if you intend to use a non-participating pharmacy. **Note**: Step Therapy and prior authorization (PA) may be required. A complete list of drugs requiring PA is available at www.express-scripts.com.
	Preferred brand drugs	**Retail**: $30 copayment (per 30-day supply), after deductible **Mail**: $60 copayment, after deductible		
	Non-preferred brand drugs	**Retail**: $50 copayment (per 30-day supply), after deductible **Mail**: $100 copayment, after deductible		
	Specialty drugs	Coverage/cost varies based on place of setting		Specialty drugs may not be available at a retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Precertification is required; penalty may apply for non-compliance.
	Physician/surgeon fees			——————none——————
If you need immediate medical attention	Emergency room services	$100 copayment for true emergency, after deductible		Non-emergent use of emergency room is not covered.
	Emergency medical transportation	No cost after deductible		——————none——————
	Urgent care	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Your costs for urgent care may vary depending on place of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Precertification is required; penalty may apply for non-compliance.
	Physician/surgeon fee			——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Drexel Preferred or Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient (OP) services	20% coinsurance	50% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Precertification required.
	Substance use disorder outpatient (OP) services	20% coinsurance	50% coinsurance	————————none————————
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Precertification required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Copayments, deductibles and/or coinsurance may apply to services other than an office visit.
	Delivery and all inpatient services			Precertification is requested.
If you need help recovering or have other special health needs	Home health care	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Precertification required.
	Rehabilitation services	20% coinsurance (No cost after deductible for Drexel Preferred speech therapy)	50% coinsurance	Maximum 30 visits/calendar year for PT and OT, 20 visits of speech (in-network and out-of-network).
	Habilitation services			
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification required. Maximum 120 days/calendar year (combined In/Out.)
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification required.
	Hospice service	20% coinsurance (No cost after deductible for Drexel Preferred)	50% coinsurance	Precertification required
If your child needs dental or eye care	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.

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.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing Aids
- Infertility treatment (AI, IVF, GIFT, ZIFT)
- Long-term care
- Non-emergency care when outside the U.S.
- Routine foot care
- Routine eye care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Private-duty nursing (maximum 360 hours/calendar year; outpatient)

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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.
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.

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. Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-355-2583.	**如果需要中文的帮助**，请拨打这个号码 1-800-355-2583. Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-355-2583.

Note: This document is only a summary. This document is only a summary, and the plan document, policy or certificate of insurance should be consulted for the complete terms of the plan and to determine governing provisions. All benefits are subject to the definitions, limitations, and exclusions set forth in the formal plan documents.

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** $5,995
- **Patient pays** $1,545

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
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copayments	$15
Coinsurance	$0
Limits or exclusions	$30
Total	**$1,545**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** $1,870

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
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copayments	$330
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,870**

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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.