

Medical Benefit Highlights

PC 20/30/70 School District of Philadelphia

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	In-Network	Out-of-Network
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$500/\$1,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$1,000/\$2,000	\$3,000/\$6,000
Coinsurance	0%	30%
Preventive Services	In-Network	Out-of-Network
Preventive Care	No charge	30% no deductible
Preventive Colonoscopy Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	\$20	30% after deductible
Specialist Office Visit	\$30	30% after deductible
Retail Health Clinic Visit	\$20	30% after deductible
MDLIVE Telemedicine	No charge	Not covered
Urgent Care Visit	\$30	30% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (60 visits/year) ³ Freestanding	Visits 1-30: \$20 Visits 31+: \$30	30% after deductible
Hospital Based	Visits 1-30: \$20 Visits 31+: \$30	30% after deductible
Occupational Therapy (60 visits/year) ³ Freestanding	Visits 1-30: \$20 Visits 31+: \$30	30% after deductible
Hospital Based	Visits 1-30: \$20 Visits 31+: \$30	30% after deductible
Speech Therapy (60 visits/year) ³	Visits 1-30: \$20 Visits 31+: \$30	30% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room (copay waived if admitted)	\$40	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible
Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year) ⁴	No charge	30% after deductible

Observation Services	No charge	30% after deductible
Maternity Hospital Services ⁴	No charge	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge	30% after deductible
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Outpatient Professional Services	No charge	30% after deductible
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	\$30	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$30	30% after deductible
Hospital Based	\$30	30% after deductible
Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)		
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge	30% after deductible
Hospital Based	No charge	30% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year) ⁵	\$30	30% after deductible
Nutrition Counseling (6 visits/year) ⁵	No charge	30% after deductible
Assisted Reproductive Technologies	No charge	30% after deductible
Acupuncture (18 visits/year) ⁵	\$30	30% after deductible
Standard Injectables	No charge	30% after deductible
Allergy Injections	No charge	30% after deductible
Biotech/Specialty Injectables	No charge	30% after deductible
Self-Administered Prescription Drugs ⁶	No charge	Not covered
Chemotherapy	No charge	30% after deductible
Dialysis	No charge	30% after deductible
Skilled Nursing Facility (120 days/year) ⁵	No charge	30% after deductible
Home Health	No charge	30% after deductible
Hospice	No charge	30% after deductible
Durable Medical Equipment (DME)	\$30	30% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	\$30	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁴	No charge	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 Physical Therapy, Occupational Therapy, and Speech Therapy combined visit limit in and out-of-network.

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.

⁶ The list of Self-Administered Prescription Drugs is available at [ibx.com](http://www.ibx.com). This list is subject to change. To access the list: Go to the Medical Policy Portal: <https://www.ibx.com/resources/for-providers/policies-and-guidelines/operations-management/medical-policy> Agree to the terms and conditions of use >>Type Self-Administered Drugs in the Search bar >> Click the magnifying glass >> Click Attachment A

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