Independence

Medical Benefit Highlights

PC 320 School District of Philadelphia

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual/Family	$300/$900	$750/$2,250
Coinsurance Maximum		
Individual/Family	$1,000/$2,000	$7,000/$14,000
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$6,350/$12,700	Not Applicable/Not Applicable
Coinsurance	10%	30%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	30% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	$20 no deductible	30% after deductible
Specialist Office Visit	$30 no deductible	30% after deductible
Retail Health Clinic Visit	$20 no deductible	30% after deductible
MDLIVE Telemedicine	No charge no deductible	Not covered
Urgent Care Visit	$50 no deductible	30% after deductible
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[3]		
Freestanding	$30 no deductible	30% after deductible
Hospital Based	$30 no deductible	30% after deductible
Occupational Therapy (60 visits/year)[3]		
Freestanding	$30 no deductible	30% after deductible
Hospital Based	$30 no deductible	30% after deductible
Speech Therapy (60 visits/year)[3]	$30 no deductible	30% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$100 no deductible	Covered at In-Network level
Emergency Ambulance	No charge after deductible	Covered at In-Network level
Non-Emergency Ambulance	10% after deductible	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]	10% after deductible	30% after deductible
Observation Services	10% after deductible	30% after deductible
Maternity Hospital Services[4]	10% after deductible	30% after deductible
Inpatient Professional Services (includes Maternity)	10% after deductible	30% after deductible

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Outpatient Surgery	In-Network	Out-of-Network
Freestanding	10% after deductible	30% after deductible
Hospital Based	10% after deductible	30% after deductible
Outpatient Professional Services	10% after deductible	30% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	10% after deductible	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	10% after deductible	30% after deductible
Hospital Based	10% after deductible	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	10% after deductible	30% after deductible
Hospital Based	10% after deductible	30% after deductible

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

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (30 visits/year)[5]	$30 no deductible	30% after deductible
Acupuncture (18 visits/year)[5]	$30 no deductible	30% after deductible
Nutrition Counseling (6 visits/year)[5]	No charge	30% after deductible
Assisted Reproductive Technologies	10% after deductible	30% after deductible
Standard Injectables	10% after deductible	30% after deductible
Allergy Injections	No charge no deductible	30% after deductible
Biotech/Specialty Injectables	10% after deductible	30% after deductible
Self-Administered Prescription Drugs	Not covered	Not covered
Chemotherapy	10% after deductible	30% after deductible
Dialysis	10% after deductible	30% after deductible
Skilled Nursing Facility	10% after deductible	30% after deductible
Home Health	10% after deductible	30% after deductible
Hospice	10% after deductible	30% after deductible
Durable Medical Equipment (DME)	10% after deductible	30% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	$30 no deductible	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[4]	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] 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.

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

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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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