

Medical Benefit Highlights

Temple University Students PPO \$250/500

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible (Embedded) ¹ Individual/Family	\$250/\$500	\$5,000/\$10,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$7,900/\$15,800	\$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 Hospital Based	No charge no deductible \$750 no deductible	Not covered 50% no deductible
Physician Services	In-Network	Out-of-Network
Primary Care Physician (PCP) Office Visit	\$20 no deductible	50% after deductible
Specialist Office Visit	\$40 no deductible	50% after deductible
Retail Health Clinic Visit	\$20 no deductible	50% after deductible
Telemedicine	\$20 no deductible	Not covered
Urgent Care Visit	\$85 no deductible	50% after deductible
Therapy Services	In-Network	Out-of-Network
Physical Therapy (30 visits/year) ³ Freestanding Hospital Based	\$40 no deductible \$40 no deductible	50% after deductible 50% after deductible
Occupational Therapy (30 visits/year) ³ Freestanding Hospital Based	\$40 no deductible \$40 no deductible	50% after deductible 50% after deductible
Speech Therapy (20 visits/year) ⁴	\$40 no deductible	50% after deductible
Emergency Services	In-Network	Out-of-Network
Emergency Room (copay not waived if admitted)	\$250 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) ⁵	20% after deductible	50% after deductible
Observation Services	20% after deductible	50% after deductible
Maternity Hospital Services ⁵	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)	\$40 no deductible	50% after deductible
Routine Radiology (X-Ray)		
Freestanding	\$40 no deductible	50% after deductible
Hospital Based	\$40 no deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$80 no deductible	50% after deductible
Hospital Based	\$80 no deductible	50% after deductible
Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	\$40 no deductible	50% after deductible
Hospital Based	\$80 no deductible	50% after deductible
Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year) ⁴	\$40 no deductible	50% after deductible
Acupuncture (18 visits/year) ⁴	\$40 no deductible	50% after deductible
Standard Injectables	No charge no deductible	50% after deductible
Allergy Injections	No charge no deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	\$100 no deductible	50% after deductible
Outpatient	\$200 no deductible	50% after deductible
Chemotherapy	20% after deductible	50% after deductible
Dialysis	20% after deductible	50% after deductible
Skilled Nursing Facility (120 days/year) ⁴	20% after deductible	50% after deductible
Home Health (60 visits/year) ⁴	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)	\$40 no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁵	20% after deductible	50% 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 and Occupational Therapy combined visit limit in and out-of-network.

⁴ Combined in and out-of-network.

⁵ 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.

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