AmeriHealth

Medical Benefit Highlights

HMO $30/50/$500

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**Referred**	**Out-of-Network**
Deductible Individual/Family	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/Family	$7,900/$15,800	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$30	Not covered
Telemedicine Visit	$20	Not covered
Specialist		
Office Visit	$50	Not covered
Telemedicine Visit	$35	Not covered
Retail Health Clinic Visit	$30	Not covered
Urgent Care Visit	$87	Not covered
Virtual Care[2]	**Referred**	**Out-of-Network**
Telemedicine	No charge	Not covered
Teledermatology	No charge	Not covered
Telebehavioral Health	No charge	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (30 visits/year)[3]		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Occupational Therapy (30 visits/year)[3]		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Speech Therapy (20 visits/year)	$50	Not covered

AmeriHealth

Emergency Services	Referred	Out-of-Network
Emergency Room (copay not waived if admitted)	$300	Covered at In-Network level
Emergency Ambulance	$50	Covered at In-Network level
Non-Emergency Ambulance	$50	Not covered

Hospital Services	Referred	Out-of-Network
Inpatient Hospital Services	$500/Day; max of 5 copays per admission	Not covered
Observation Services (copay waived if admitted)	$300	Not covered
Maternity Hospital Services	$500/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	Not covered

Outpatient Surgery	Referred	Out-of-Network
Freestanding	$500	Not covered
Hospital Based	$500	Not covered
Outpatient Professional Services	No charge	Not covered

Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	$50	Not covered
Routine Radiology (X-Ray)		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$50	Not covered
Hospital Based	$50	Not covered

Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered

Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (20 visits/year)	$50	Not covered
Acupuncture (18 visits/year)	$50	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables		
Home/Office	$150	Not covered
Outpatient	$150	Not covered
Chemotherapy	$30	Not covered

Dialysis	$30	Not covered
Skilled Nursing Facility (120 days/year)	$250/Day; max of 5 copays per admission	Not covered
Home Health (60 visits/year)	$30	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment (DME)	50%	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$50	Not covered
All Other Services	$50	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$500/Day; max of 5 copays per admission	Not covered
Routine Eye Care	$50	Not covered

1 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.

2 Telemedicine is provided by a designated telemedicine provider, please visit **www.amerihealth.com/findcarenow**.

3 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit.

AmeriHealth is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by an AmeriHealth primary care physician (PCP). Your AmeriHealth PCP may also refer you to other AmeriHealth providers for care, if needed. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their AmeriHealth members. You can view the sites selected by your PCP at **www.amerihealth.com**.

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.amerihealth.com/LGBooklet** or call **1-800-275-2583** (TTY: 711).

Benefits may be changed by AmeriHealth 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.amerihealth.com/preapproval** or call the phone number that is listed on the back of your identification card.

AmeriHealth HMO Benefits are underwritten or administered by AmeriHealth HMO, Inc. **www.amerihealth.com**

Independence

Drug Benefit Highlights

Rothman HMO-POS Select RX Rider $25/$50/$75

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	$0/$0
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Formulary[1]	Premium	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$25	30% Reimbursement
Tier 2 Preferred Brand Drugs	$50	30% Reimbursement
Tier 3 Non-Preferred Drugs	$75	30% Reimbursement
Tier 4 Self-Administered Specialty Drugs	10% up to $250	Not covered
Dispensing Limits[2]	30 day supply max	30 day supply max
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$50	Not covered
Tier 2 Preferred Brand Drugs	$100	Not covered
Tier 3 Non-Preferred Drugs	$150	Not covered
Tier 4 Self-Administered Specialty Drugs	Not covered	Not covered
Dispensing Limits	90 day supply max	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[3]	Covered	Covered
Compound Medications	Covered	Covered
Contraceptives	Covered	Covered
Diabetic Supplies (i.e., test strips)	Covered	Covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Injectable Fertility Drugs	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Covered
Allergy Serum	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered

Independence

Weight Control Drugs	Not covered	Not covered

1 Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto **www.ibx.com**.

2 Up to a 90-day supply of drugs to treat chronic conditions available at any participating retail pharmacy or mail for same cost share.

3 Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug 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 pharmacy policy. As a result, this program 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).

Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order are not covered. Devices or supplies except those specifically listed under covered drugs are not covered.

All covered self-administered specialty medications will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.

The pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

Independence

Vision Benefit Highlights

$100 Eyewear Benefit- Biennial - Fully Insured

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers	Not covered	Not covered
Retinal Imaging	$39	Not covered
Lenses (1 pair/Every 24 Months)[1]	**In-Network**	**Out-of-Network[2]**
Single Vision Lenses	No charge	$100 Reimbursement[3]
Bifocal Lenses	No charge	$100 Reimbursement[3]
Trifocal Lenses	No charge	$100 Reimbursement[3]
Lenticular Lenses	No charge	$100 Reimbursement[3]
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/ Ultimate	$50/$90/$140/$175	$100 Reimbursement[3]
Polycarbonate Lenses - Single/Multifocal[4]	$30	Not covered
Digital/Intermediate Lenses	$30	Not covered
Photochromic Lenses - Single/Multifocal	$15/$25	Not covered
Photosensitive Lenses - Single/Multifocal	$60/$70	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	$55/$120	Not covered
Blue Light Lenses	$15	Not covered
Polarized Lenses	$60	Not covered
Lens Coatings		
Tinted Plastic Lenses	No charge	Not covered
UV-Coated Lenses	$12	Not covered
Scratch-Resistant Coating - Single/Multifocal	$15/$25	Not covered
Scratch-Protection Plan - Single/Multifocal	Not covered	Not covered
Anti-Reflective Coating - Standard/Premium/ Ultra/Ultimate	$33/$48/$60/$85	Not covered
Frames (1 pair/Every 24 Months)[1]	**In-Network**	**Out-of-Network**
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	No charge	Not covered
Collection Premier Frames	No charge	Not covered
Non-Collection Frames	Up to $65 Allowance (plus a 20% discount on overage)[5]	$100 Reimbursement[3]
Visionworks Frames Option	Up to $65 Allowance (plus a 20% discount on overage)[5]	Not covered

Independence

Contact Lenses (in lieu of glasses) (1 pair/ Every 24 Months)[1]	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	Not covered	Not covered
Collection Contact Lenses	Not covered	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care[6]	Up to $100 Allowance	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care[6]	Up to $100 Allowance	Not covered
Non-Collection Contact Lenses	Up to $100 Allowance[5]	$100 Reimbursement
Medically-Necessary Contact Lenses[7]	No charge	$225 Reimbursement

1 Combined in and out-of-network.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Combined reimbursement.

4 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

5 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

6 Only covered with purchase of Non-Collection Contact Lenses.

7 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations 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.

Administered by Davis Vision.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

Reference ID: 1004276703012025

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Telugu: శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిస్తాయి. 1-800-275-2583 (TTY: 711) కు కాల్ చేయండి.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Taglines as of 12/31/2022

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.