

Medical Benefit Highlights

PPO HSA \$5,000/80% w Int Rx

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible (Aggregate) ¹ Individual/Family	\$5,000/\$10,000	\$6,000/\$12,000
Out-of-Pocket Maximum (See Footnote) ² Individual/Family	\$7,000/\$14,000	\$12,000/\$24,000
Coinsurance	20%	50%
Preventive Services		
Preventive Care	No charge no deductible	50% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	\$750 no deductible	50% no deductible
Physician Services		
Primary Care Physician (PCP)		
Office Visit	20% after deductible	50% after deductible
Telemedicine Visit	20% after deductible	50% after deductible
Specialist		
Office Visit	20% after deductible	50% after deductible
Telemedicine Visit	20% after deductible	50% after deductible
Retail Health Clinic Visit	20% after deductible	50% after deductible
Urgent Care Visit	20% after deductible	50% after deductible
Virtual Care³		
Telemedicine	No charge after deductible	Not covered
Teledermatology	No charge after deductible	Not covered
Telebehavioral Health	No charge after deductible	Not covered
Therapy Services		
Physical Therapy (30 visits/year) ⁴		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Occupational Therapy (30 visits/year) ⁴		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Speech Therapy (20 visits/year) ⁵	20% after deductible	50% after deductible

Emergency Services	In-Network	Out-of-Network
Emergency Room	20% 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) ⁶	20% after deductible	50% after deductible
Observation Services	20% after deductible	50% after deductible
Maternity Hospital Services ⁶	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)	20% after deductible	50% after deductible
Routine Radiology (X-Ray)		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year) ⁵	20% after deductible	50% after deductible
Acupuncture (18 visits/year) ⁵	20% after deductible	50% after deductible
Standard Injectables	No charge after deductible	50% after deductible
Allergy Injections	No charge after deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Chemotherapy	20% after deductible	50% after deductible
Dialysis	20% after deductible	50% after deductible

Skilled Nursing Facility (120 days/year) ⁵	20% after deductible	50% after deductible
Home Health (60 visits/year) ⁵	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)		
Office Visit	20% after deductible	50% after deductible
All Other Services	20% after deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁶	20% after deductible	50% after deductible

- 1 Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.
- 2 In-Network 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. Out-of-Network aggregate out-of-pocket maximum: For family coverage, the entire family out-of-pocket maximum must be met before copayments or coinsurance are applied for an individual member.
- 3 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.
- 4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 5 Combined in and out-of-network.
- 6 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

The Preferred Provider Organization (PPO) program gives you the freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided by preferred providers who participate in the BlueCard® PPO program (these are network providers). If you access care from a provider who does not participate in the BlueCard® PPO Program, 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

Drug Benefit Highlights

PPO HSA \$5,000/80% Integrated Rx

Covered Services

Benefits per Contract Year

Deductible
Out-of-Pocket Maximum
Formulary ¹

Retail Pharmacy

Tier 1 Low-Cost Generic Drugs
Tier 2 Generic Drugs
Tier 3 Preferred Brand Drugs
Tier 4 Non-Preferred Drugs
Tier 5 Self-Administered Specialty Drugs
Dispensing Limits ^{2,3}

Mail Order Pharmacy Available for maintenance drugs

Tier 1 Low-Cost Generic Drugs
Tier 2 Generic Drugs
Tier 3 Preferred Brand Drugs
Tier 4 Non-Preferred Drugs
Tier 5 Self-Administered Specialty Drugs
Dispensing Limits

Drug Coverage

ACA Preventive Drugs ⁴
Compound Medications
Contraceptives
Diabetic Supplies (i.e., test strips)
Glucometers (no copayment/coinsurance required at participating pharmacies after deductible)
Injectable Fertility Drugs
Insulin
Insulin Needles and Syringes
Lancets (no copayment/coinsurance required at participating pharmacies after deductible)
Prescribed Tobacco Cessation Drugs (RX and OTC)

Your Costs (You pay)

In-Network

Medical deductible applies.
Combined with Medical Premium

In-Network

\$5 after deductible
\$20 after deductible
\$40 after deductible
\$70 after deductible
50% up to \$500 after deductible
30 day supply max

In-Network

\$10 after deductible
\$40 after deductible
\$80 after deductible
\$140 after deductible
Not covered
90 day supply max

In-Network

Covered

Out-of-Network

Medical deductible applies.
Combined with Medical

Out-of-Network

50% Reimbursement after deductible
Not covered
30 day supply max

Out-of-Network

Not covered

Out-of-Network

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
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 Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.
- 3 Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid or mail for same cost share.
- 4 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 QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

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 કોલ 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: క్షణ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగా లభిస్తాయి. 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 schwetzsch, 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'déé', t'áá jiik'eh. Hódííłnih kojí' 1-800-275-2583.

Urdu:

توجہ درکار ہے: 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: សូមមេត្តាចាំបំរើអារម្មណ៍៖

ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

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: civilrightscordinator@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>.