

Medical Benefit Highlights

PPO \$3,000/\$30-\$60/90%

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	In-Network	Out-of-Network
Deductible (Embedded) ¹ Individual/Family	\$3,000/\$6,000	\$5,000/\$10,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$7,900/\$15,800	\$10,000/\$20,000
Coinsurance	10%	50%
Preventive Services	In-Network	Out-of-Network
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	In-Network	Out-of-Network
Primary Care Physician (PCP)		
Office Visit	\$30 no deductible	50% after deductible
Telemedicine Visit	\$20 no deductible	50% after deductible
Specialist		
Office Visit	\$60 no deductible	50% after deductible
Telemedicine Visit	\$40 no deductible	50% after deductible
Retail Health Clinic Visit	\$30 no deductible	50% after deductible
Urgent Care Visit	\$100 no deductible	50% after deductible
Virtual Care ³	In-Network	Out-of-Network
Telemedicine	No charge no deductible	Not covered
Teledermatology	No charge no deductible	Not covered
Telebehavioral Health	No charge no deductible	Not covered
Therapy Services	In-Network	Out-of-Network
Physical Therapy (30 visits/year) ⁴		
Freestanding	\$60 no deductible	50% after deductible
Hospital Based	\$60 no deductible	50% after deductible
Occupational Therapy (30 visits/year) ⁴		
Freestanding	\$60 no deductible	50% after deductible
Hospital Based	\$60 no deductible	50% after deductible
Speech Therapy (20 visits/year) ⁵	\$60 no deductible	50% after deductible

Emergency Services

Emergency Room (copay not waived if admitted)

Emergency Ambulance

Non-Emergency Ambulance

In-Network

\$300 after deductible

\$150 no deductible

\$150 no deductible

Out-of-Network

Covered at In-Network level

Covered at In-Network level

50% after deductible

Hospital Services

Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)⁶

Observation Services

Maternity Hospital Services⁶

Inpatient Professional Services (includes Maternity)

In-Network

10% after deductible

10% after deductible

10% after deductible

10% after deductible

Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

Outpatient Surgery

Freestanding

Hospital Based

Outpatient Professional Services

In-Network

\$300 after deductible

\$300 after deductible

10% after deductible

Out-of-Network

50% after deductible

50% after deductible

50% after deductible

Outpatient Diagnostics

Diagnostic Medical (EKG)

Routine Radiology (X-Ray)

Freestanding

Hospital Based

Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)

Freestanding

Hospital Based

In-Network

\$60 no deductible

\$60 no deductible

\$60 no deductible

\$200 no deductible

\$200 no deductible

Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

Outpatient Lab and Pathology

Freestanding

Hospital Based

In-Network

\$60 no deductible

\$120 no deductible

Out-of-Network

50% after deductible

50% after deductible

Other Medical Services

Spinal Manipulations (20 visits/year)⁵

Acupuncture (18 visits/year)⁵

Standard Injectables

Allergy Injections

Biotech/Specialty Injectables

Home/Office

Outpatient

Chemotherapy

In-Network

\$60 no deductible

\$60 no deductible

No charge no deductible

No charge no deductible

\$150 no deductible

\$300 no deductible

10% after deductible

Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

Dialysis	10% after deductible	50% after deductible
Skilled Nursing Facility (120 days/year) ⁵	10% after deductible	50% after deductible
Home Health (60 visits/year) ⁵	10% after deductible	50% after deductible
Hospice	10% after deductible	50% after deductible
Durable Medical Equipment (DME)	10% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	\$60 no deductible	50% after deductible
All Other Services	\$60 no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) ⁶	10% 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 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.
- 4 Physical Therapy and Occupational 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 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/LGIACBooklet 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 Independence Assurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Drug Benefit Highlights

Value Rx \$3/\$20/\$40/\$70/50% up to \$1,000

Covered Services		Your Costs (You pay)	
Benefits per Contract Year		In-Network	Out-of-Network
Deductible		\$0/\$0	\$0/\$0
Out-of-Pocket Maximum		Combined with Medical	Combined with Medical
Formulary ¹		Value	
Retail Pharmacy		In-Network	Out-of-Network
Tier 1 Low-Cost Generic Drugs		\$3	30% Reimbursement
Tier 2 Generic Drugs		\$20	30% Reimbursement
Tier 3 Preferred Brand Drugs		\$40	30% Reimbursement
Tier 4 Non-Preferred Drugs		\$70	30% Reimbursement
Tier 5 Self-Administered Specialty Drugs		50% up to \$1,000	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 Low-Cost Generic Drugs		\$6	Not covered
Tier 2 Generic Drugs		\$40	Not covered
Tier 3 Preferred Brand Drugs		\$80	Not covered
Tier 4 Non-Preferred Drugs		\$140	Not covered
Tier 5 Self-Administered Specialty Drugs		Not covered	Not covered
Dispensing Limits ³		90 day supply max	Not covered
Drug Coverage		In-Network	Out-of-Network
ACA Preventive Drugs ⁴		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
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
Weight Control Drugs		Covered	Covered
Allergy Serum		Not covered	Not covered
Blood, Blood Plasma		Not covered	Not covered
Drugs used for Cosmetic Purposes		Not covered	Not covered
Injectable Fertility Drugs		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

- 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

Vision Benefit Highlights

Vision Care 150: 12/12/24

Covered Services (Calendar Year)		Your Costs (You pay)	
Exam		In-Network	Out-of-Network
Routine Eye Exam at Davis Participating Providers (1 exam/year) ¹		\$10	\$40 Reimbursement
Retinal Imaging		\$39	Not covered
Lenses (1 pair/year) ¹		In-Network	Out-of-Network ²
Single Vision Lenses		\$25	\$40 Reimbursement
Bifocal Lenses		\$25	\$60 Reimbursement
Trifocal Lenses		\$25	\$80 Reimbursement
Lenticular Lenses		\$25	\$100 Reimbursement
Lens Options		In-Network	Out-of-Network
Progressive Lenses - Standard/Premium/Ultra/Ultimate		No charge/\$40/\$90/\$125	\$60 Reimbursement
Polycarbonate Lenses - Single/Multifocal ³		No charge	Not covered
Digital/Intermediate Lenses		No charge	Not covered
Photochromic Lenses - Single/Multifocal		No charge	Not covered
Photosensitive Lenses - Single/Multifocal		\$65	Not covered
High-Index 1.67 / High-Index 1.74 Lenses		\$55/\$120	Not covered
Blue Light Lenses		\$15	Not covered
Polarized Lenses		\$75	Not covered
Lens Coatings			
Tinted Plastic Lenses		No charge	Not covered
UV-Coated Lenses		No charge	Not covered
Scratch-Resistant Coating - Single/Multifocal		No charge	Not covered
Scratch-Protection Plan - Single/Multifocal		\$20/\$40	Not covered
Anti-Reflective Coating - Standard/Premium/Ultra/Ultimate		\$35/\$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 \$150 Allowance (plus a 20% discount on overage) ⁴	\$50 Reimbursement
Visionworks Frames Option		Up to \$200 Allowance (plus a 20% discount on overage) ⁴	Not covered

Contact Lenses (in lieu of glasses) (1 pair/year) ¹	In-Network	Out-of-Network
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	No charge	Not covered
Collection Contact Lenses	Disposable Boxes/ Multipacks: 8 per year Planned Replacement Boxes/ Multipacks: 4 per year	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	No charge	Not covered
Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to \$60 Allowance	Not covered
Non-Collection Contact Lenses	Up to \$150 Allowance ⁴	\$105 Reimbursement
Medically-Necessary Contact Lenses ⁵	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 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

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

5 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, an Independent Company.

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 નિઃશુલ્ક 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: శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లైతే, 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 schwetzscht, kannscht du Hilf griegie 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. Hódíłnìh kojì' 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: សូមមេត្តាចាបំអារម្មណ៍៖

ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ៖

ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥត

គិតថ្លៃ។ 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>.