Independence

Medical Benefit Highlights

The Preferred Provider Organization Tier 1 - Devereux

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Individual and Dependents/Family	$330/$500/$660	Not covered
Out-of-Pocket Maximum (Embedded)[2] Individual/Individual and Dependents/Family	$1,450/$2,190/$2,900	Not covered
Coinsurance	15%	Not covered
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$20 no deductible	Not covered
Telemedicine Visit	$20 no deductible	Not covered
Specialist		
Office Visit	$50 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered
Retail Health Clinic Visit	$20 no deductible	Not covered
Urgent Care Visit	$50 no deductible	Not covered
Virtual Care[3]	**In-Network**	**Out-of-Network**
Telemedicine	$10 no deductible	Not covered
Teledermatology	$10 no deductible	Not covered
Telebehavioral Health	$10 no deductible	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Occupational Therapy (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Speech Therapy (60 visits/year)[4]	$40 no deductible	Not covered
Emergency Services[6]	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$275 no deductible	Covered at In-Network level
Emergency Ambulance	15% after deductible	Covered at In-Network level
Non-Emergency Ambulance	15% after deductible	Not covered
Hospital Services[5]	**In-Network**	**Out-of-Network**
Inpatient Hospital Services	$250/Admission after deductible, then 15%	Not covered

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Observation Services	15% after deductible	Not covered
Maternity Hospital Services	$250/Admission after deductible, then 15%	Not covered
Inpatient Professional Services (includes Maternity)	15% after deductible	Not covered

Outpatient Surgery[5]	In-Network	Out-of-Network
Freestanding	15% after deductible	Not covered
Hospital Based	15% after deductible	Not covered
Outpatient Professional Services	15% after deductible	Not covered

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	15% after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	15% after deductible	Not covered
Hospital Based	15% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$100 after deductible, then 15%	Not covered
Hospital Based	$100 after deductible, then 15%	Not covered

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (15 visits/year)	$40 no deductible	Not covered
Acupuncture (18 visits/year)	$50 no deductible	Not covered
Standard Injectables	15% after deductible	Not covered
Allergy Injections	15% after deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	15% after deductible	Not covered
Outpatient	15% after deductible	Not covered
Chemotherapy	15% after deductible	Not covered
Dialysis	15% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	15% after deductible	Not covered
Home Health	15% after deductible	Not covered
Hospice	15% after deductible	Not covered
Durable Medical Equipment (DME)	No charge after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse; Out-of-Network: 20 visits/ year, 120 visits/ lifetime)	$20 no deductible	50% After deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse; Out-of-Network: 30 days/ year, 90 days/ lifetime)	No charge after deductible	50% After deductible

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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. Please note: Bariatric Surgery is excluded from the out-of-pocket max.

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

4 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit.

5 Blue Distinction Specialty Care Program: To maximize your coverage, all treatment for the following services must be coordinated through a Blue Distinction Center Plus (+) or Blue Distinction Center: bariatric surgery, cardiac care, knee/hip replacement, maternity, spine surgery and transplants. Check HYPERLINK **www.ibx.com** to search for a local provider or contact us at 1-800-ASK-BLUE.

6 Emergency Room Co-Pay waived if admitted.

The EPO Program provides in-network-only benefits through the Personal Choice® or BlueCard® PPO networks. Except for emergency services, all care must be received from participating Personal Choice network or BlueCard PPO network providers. There is no benefit coverage for care received from non-preferred, non-participating providers.

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**

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Drug Benefit Highlights

Freestanding Premium 15%/35%50%

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1]	$3,600/$5,400/$7,200	Not covered
Formulary[2]	Premium	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network[4]**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits	30 day supply max	Not covered
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits[5]	100 day supply max	Not covered
Mandatory Mail for Maintenance Drugs[6]	Yes	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[7]	Covered	Not covered
Compound Medications	Covered	Not covered
Contraceptives	Covered	Not covered
Diabetic Supplies (i.e., test strips)	Covered	Not covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Insulin	Covered	Not covered
Insulin Needles and Syringes	Covered	Not covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Not covered
Retin-A (up to Age 35)	Covered	Not covered
Allergy Serum	Not covered	Not covered
Biologicals, Investigational/Experimental Drugs	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Immunization Agents	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered

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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 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, prior to receiving plan benefits.

2 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**.

3 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.

4 Non-participating retail pharmacy purchases are not covered except in an emergency or urgent care situation.

5 CVS90 Saver Plus - 90-day supply of drugs to treat chronic conditions must be obtained at CVS or mail for same cost share, except first two fills may be 30-day fills obtained at any participating retail pharmacy.

6 All covered medications for chronic conditions (such as blood pressure medications) will be provided through our convenient mail order service, which allows you to order up to a 100-day supply. This benefit can save you time and money. If your doctor wants you to start the drug immediately, your initial supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through our convenient mail order service. Member cost sharing is indicated above.

7 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. Drugs used to treat hemophilia are not covered.

All covered self-administered specialty medications except insulin 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**

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Vision Benefit Highlights

Vision Care 130: 12/12/12

Covered Services	Your Costs (You pay)	
Benefits	**In-Network[1]**	**Out-of-Network**
Annual Plan Maximum	Unlimited	Unlimited
Deductible (Individual/Family)	$0/$0	$0/$0
Out-of-Pocket Maximum (Individual/Family)	$0/$0	$0/$0
Exam	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	1 / Calendar Year	1 / Calendar Year
Routine Eye Exam at Davis Participating Providers	No charge	$40 Reimbursement
Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 / Calendar Year	1 / Calendar Year
Single Vision Lenses	No charge	$40 Reimbursement
Bifocal Lenses	No charge	$60 Reimbursement
Trifocal Lenses	No charge	$80 Reimbursement
Lenticular Lenses	No charge	$100 Reimbursement
Lens Options[3]		
Standard Progressive Lenses	$50	$60 Reimbursement
Premium Progressive Lenses	$90	$60 Reimbursement
Ultra Progressive Lenses	$140	$60 Reimbursement
Ultimate Progressive Lenses	$175	$60 Reimbursement
Polycarbonate Lenses - Single Vision[4]	$30	Not applicable
Polycarbonate Lenses - Multifocal Vision[4]	$30	Not applicable
Photosensitive Lenses – Single Vision	$65	Not applicable
Photosensitive Lenses – Multifocal Vision	$65	Not applicable
High-Index Lenses	$55	Not applicable
High-Index 1.74 Lenses	$120	Not applicable
Blue Light Lenses	$15	Not applicable
Polarized Lenses	$75	Not applicable
Lens Coatings		
Tinted Plastic Lenses	No charge	Not applicable
UV-Coated Lenses	No charge	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	No charge	Not applicable
Scratch-Resistant Coating Multifocal Lenses	No charge	Not applicable
Scratch-Protection Plan Single Vision Lenses	$20	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	$40	Not applicable
Anti-Reflective Standard Lenses	$35	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable

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Anti-Reflective Ultimate Lenses	$85	Not applicable

Frames	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Calendar Year	1 / Calendar Year
Davis Collection Fashion Frames	No charge	Not applicable
Davis Collection Designer Frames	No charge	Not applicable
Davis Collection Premier Frames	$25	Not applicable
Non-Davis Collection Frames	Up to $130 Allowance (plus a 20% discount on overage)[5]	$50 Reimbursement
Visionworks Frames Option	Up to $180 Allowance (plus a 20% discount on overage)[5]	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Calendar Year	1 / Calendar Year
Davis Collection Standard Daily Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	No charge	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $130 Allowance; Evaluation: Up to $60 Allowance; (plus a 15% discount on overage)[5]	$105 Reimbursement
Medically-Necessary Contact Lenses[6]	No charge	$225 Reimbursement

1 Participating Davis provider benefit.

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

3 Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

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 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 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.

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។

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*.