

Medical Benefit Highlights

The Preferred Provider Organization HDHP IND/FAM - Devereux

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	In-Network	Out-of-Network
Deductible (Aggregate) ¹		
Individual / EE+Child / Family (EE/SP/DP, EE+Children, Family)	\$3,410/\$6,815	Not covered
Out-of-Pocket Maximum (Aggregate) ²		
Individual / EE+Child / Family (EE/SP/DP, EE+Children, Family)	\$5,200/\$10,400	Not covered
Coinsurance	25%	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	25% after deductible	Not covered
Telemedicine Visit	25% after deductible	Not covered
Specialist		
Office Visit	25% after deductible	Not covered
Telemedicine Visit	25% after deductible	Not covered
Retail Health Clinic Visit	25% after deductible	Not covered
Urgent Care Visit	25% after deductible	Not covered
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 (60 visits/year) ⁴		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Occupational Therapy (60 visits/year) ⁴		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Speech Therapy (20 visits/year)	25% after deductible	Not covered
Emergency Services	In-Network	Out-of-Network
Emergency Room	25% after deductible	Covered at In-Network level
Emergency Ambulance	25% after deductible	Covered at In-Network level
Non-Emergency Ambulance	25% after deductible	Not covered
Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services	25% after deductible	Not covered
Observation Services	25% after deductible	Not covered

Maternity Hospital Services	25% after deductible	Not covered
Inpatient Professional Services (includes Maternity)	25% after deductible	Not covered
Outpatient Surgery		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Outpatient Professional Services	25% after deductible	Not covered
Outpatient Diagnostics		
Diagnostic Medical (EKG)	25% after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Outpatient Lab and Pathology		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Other Medical Services		
Spinal Manipulations (15 visits/year)	25% after deductible	Not covered
Acupuncture (18 visits/year)	25% after deductible	Not covered
Standard Injectables	25% after deductible	Not covered
Allergy Injections	25% after deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	25% after deductible	Not covered
Outpatient	25% after deductible	Not covered
Chemotherapy	25% after deductible	Not covered
Dialysis	25% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	25% after deductible	Not covered
Home Health	25% after deductible	Not covered
Hospice	25% after deductible	Not covered
Durable Medical Equipment (DME)	25% after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	25% after deductible	Not covered
All Other Services	25% after deductible	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	25% after deductible	Not covered

1 Aggregate Deductible: For the EE + Child and Family (Includes EE/SP/DP & EE/Children) tiers, the entire tiered deductible must be met before copayments and coinsurance are applied for an individual member.

2 Aggregate out-of-pocket maximum: For the EE + Child and Family (Includes EE/SP/DP & EE/Children) tiers, the entire tiered out-of-pocket maximum must be met before copayments and coinsurance no longer apply for the remainder of the plan year.

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.



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

Drug Benefit Highlights

Devereux Closed Panel HDHP HSA w/Integ. Rx

Covered Services		Your Costs (You pay)	
Benefits per Calendar Year		In-Network	Out-of-Network
Deductible		Medical deductible applies.	Not covered
Out-of-Pocket Maximum		Combined with Medical	Not covered
Formulary		Select	
Retail Pharmacy		In-Network	Out-of-Network
Tier 1 Generic Drugs		25% after deductible	Not covered
Tier 2 Preferred Brand Drugs		25% after deductible	Not covered
Tier 3 Non-Preferred Drugs		25% after deductible	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		25% after deductible	Not covered
Tier 2 Preferred Brand Drugs		25% after deductible	Not covered
Tier 3 Non-Preferred Drugs		25% after deductible	Not covered
Dispensing Limits		90 day supply max	Not covered
Drug Coverage		In-Network	Out-of-Network
ACA Preventive Drugs ¹		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 after deductible)		Covered	Not covered
Insulin		Covered	Not covered
Insulin Needles and Syringes		Covered	Not covered
Lancets (no copayment/coinsurance required at participating pharmacies after deductible)		Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)		Covered	Not covered
Allergy Serum		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
Weight Control Drugs		Not covered	Not covered

¹ 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 preventative 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 130: 12/12/12

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		No charge	\$40 Reimbursement
Retinal Imaging		\$39	Not covered
Lenses (1 pair/year) ¹		In-Network	Out-of-Network ²
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		In-Network	Out-of-Network
Progressive Lenses - Standard/Premium/Ultra/Ulimate		\$50/\$90/\$140/\$175	\$60 Reimbursement
Polycarbonate Lenses - Single/Multifocal ³		\$30	Not covered
Digital/Intermediate Lenses		\$30	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/Ulimate		\$35/\$48/\$60/\$85	Not covered
Frames (1 pair/year) ¹		In-Network	Out-of-Network
Collection Fashion Frames		No charge	Not covered
Collection Designer Frames		No charge	Not covered
Collection Premier Frames		\$25	Not covered
Non-Collection Frames		Up to \$130 Allowance (plus a 20% discount on overage) ⁴	\$50 Reimbursement
Visionworks Frames Option		Up to \$180 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: 4 per year Planned Replacement Boxes/Multipacks: 2 per year	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care		Up to \$60 Allowance	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 \$130 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.

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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: 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 yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih 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:

សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ 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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: civilrightscordinator@1901market.com.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at the following website:
www.healthinsurancehosting.com/notices.