# Medical Benefit Highlights
**Drexel University PHO High Option PC-15**

## Covered Services

<table>
<thead>
<tr>
<th>Benefits per Calendar Year</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (Embedded)</strong></td>
<td>$0/$0</td>
<td>$500/$1,000</td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum (Embedded)</strong></td>
<td>$1,000/$2,000</td>
<td>$2,000/$4,000</td>
<td>$3,000/$6,000</td>
</tr>
<tr>
<td>Individual/Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total Maximum Out-of-Pocket (Embedded)</strong></td>
<td>$2,000/$4,000</td>
<td>$2,000/$4,000</td>
<td>$3,000/$6,000</td>
</tr>
<tr>
<td>Individual/Family</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Preventive Services

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Colonoscopy</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive Plus Providers</td>
<td>No charge</td>
<td>No charge</td>
<td>20% no deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>

## Physician Services

<table>
<thead>
<tr>
<th>Primary Care Physician (PCP)</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>No charge</td>
<td>$15</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Telemedicine Visit</td>
<td>No charge</td>
<td>$15</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$10</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$10</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Telemedicine Visit</td>
<td>No charge</td>
<td>$15</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>No charge</td>
<td>$35</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Virtual Care

<table>
<thead>
<tr>
<th>Virtual Care</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teledermatology</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telebehavioral Health</td>
<td>No charge</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Therapy Services

<table>
<thead>
<tr>
<th>Therapy Services</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy (60 visits/year)</td>
<td>No charge</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (60 visits/year)</td>
<td>No charge</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (60 visits/year)</td>
<td>No charge</td>
<td>$25</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Emergency Services

<table>
<thead>
<tr>
<th>Emergency Services</th>
<th>In-Network Tier 1</th>
<th>In-Network Tier 2</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room (copay waived if admitted)</td>
<td>$100</td>
<td></td>
<td>Covered at In-Network level</td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td>No charge</td>
<td></td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td>No charge</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>In-Network Tier 1</td>
<td>In-Network Tier 2</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)\(^5\)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Services</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Maternity Hospital Services(^5)</td>
<td>$100</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

### Observation Services

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Surgery

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Observation Services

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Professional Services (includes Maternity)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Diagnostics

#### Diagnostic Medical (EKG)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Routine Radiology (X-Ray)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Lab and Pathology

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Other Medical Services

#### Spinal Manipulations (30 visits/year)\(^6\)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>$25</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Acupuncture (18 visits/year)\(^5\)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>$10</th>
<th>$25</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Standard Injectables

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Allergy Injections

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Biotech/Specialty Injectables

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network Tier 1</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Home/Office Outpatient

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Chemotherapy

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Dialysis

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Skilled Nursing Facility (120 days/year)\(^6\)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>$25</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Home Health

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Hospice

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Durable Medical Equipment (DME)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>No charge</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Mental Health – Outpatient (includes serious mental illness and substance abuse)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Office Visit

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### All Other Services

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

#### Mental Health – Inpatient (includes serious mental illness and substance abuse)\(^5\)

<table>
<thead>
<tr>
<th>Freestanding</th>
<th>In-Network</th>
<th>Not covered</th>
<th>No charge</th>
<th>20% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>No charge</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

---

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.
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.

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

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.

Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

Combined in and out-of-network.

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/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

**Drexel University PC 15 Rx $10/$30/$50**

## Covered Services

<table>
<thead>
<tr>
<th>Benefits per Calendar Year</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0/$0</td>
<td>$0/$0</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Combined with Medical Premium</td>
<td>Combined with Medical</td>
</tr>
<tr>
<td>Formulary&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Retail Pharmacy

<table>
<thead>
<tr>
<th>Tier 1 Generic Drugs</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10</td>
<td>30% Reimbursement</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand Drugs</td>
<td>$30</td>
<td>30% Reimbursement</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$50</td>
<td>30% Reimbursement</td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>30 day supply max</td>
<td>30 day supply max</td>
</tr>
</tbody>
</table>

### Mail Order Pharmacy

**Available for maintenance drugs**

<table>
<thead>
<tr>
<th>Tier 1 Generic Drugs</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand Drugs</td>
<td>$60</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$100</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dispensing Limits&lt;sup&gt;2&lt;/sup&gt;</td>
<td>90 day supply max</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Drug Coverage

<table>
<thead>
<tr>
<th>ACA Preventive Drugs&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compound Medications</td>
<td>Covered</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies (i.e., test strips)</td>
<td>Covered</td>
</tr>
<tr>
<td>Glucometers (no copayment/coinsurance required at participating pharmacies)</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin Needles and Syringes</td>
<td>Covered</td>
</tr>
<tr>
<td>Lancets (no copayment/coinsurance required at participating pharmacies)</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescribed Tobacco Cessation Drugs (RX and OTC)</td>
<td>Covered</td>
</tr>
<tr>
<td>Weight Control Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>Not covered</td>
</tr>
<tr>
<td>Blood, Blood Plasma</td>
<td>Not covered</td>
</tr>
<tr>
<td>Drugs used for Cosmetic Purposes</td>
<td>Not covered</td>
</tr>
<tr>
<td>Injectable Fertility Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>Investigational/Experimental Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-Federal Legend Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>Over-The-Counter Drugs (Non-Prescription)</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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 QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com
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.