

Medical Benefit Highlights

Keystone HMO Villanova University

| Covered Services | Your Costs (You pay) | |
|--|-------------------------|----------------|
| Benefits per Contract Year | Referred | Out-of-Network |
| Deductible (Embedded) ¹ Individual/Family | \$250/\$500 | Not covered |
| Out-of-Pocket Maximum (Embedded) ² Individual/Family | \$3,300/\$6,600 | Not covered |
| Coinsurance | 0% | Not covered |
| <hr/> | | |
| Preventive Services | Referred | 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 |
| <hr/> | | |
| Physician Services | Referred | Out-of-Network |
| Primary Care Physician (PCP) | | |
| Office Visit | \$20 no deductible | Not covered |
| Telemedicine Visit | \$20 no deductible | Not covered |
| Specialist | | |
| Office Visit | \$40 no deductible | Not covered |
| Telemedicine Visit | \$40 no deductible | Not covered |
| Retail Health Clinic Visit | \$20 no deductible | Not covered |
| Urgent Care Visit | \$50 no deductible | Not covered |
| <hr/> | | |
| Virtual Care ³ | Referred | 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 |
| <hr/> | | |
| Therapy Services | Referred | Out-of-Network |
| Physical Therapy (30 visits/year) ⁴ | | |
| Freestanding | \$40 no deductible | Not covered |
| Hospital Based | \$40 no deductible | Not covered |
| Occupational Therapy (30 visits/year) ⁴ | | |
| Freestanding | \$40 no deductible | Not covered |
| Hospital Based | \$40 no deductible | Not covered |
| Speech Therapy (20 visits/year) | \$40 no deductible | Not covered |

Emergency Services

| |
|---|
| Emergency Room (copay waived if admitted) |
| Emergency Ambulance |
| Non-Emergency Ambulance |

Hospital Services

| |
|--|
| Inpatient Hospital Services |
| Observation Services (copay waived if admitted) |
| Maternity Hospital Services |
| Inpatient Professional Services (includes Maternity) |

Outpatient Surgery

| |
|----------------------------------|
| Freestanding |
| Hospital Based |
| Outpatient Professional Services |

Outpatient Diagnostics

| |
|--|
| Diagnostic Medical (EKG) |
| Routine Radiology (X-Ray) |
| Freestanding |
| Hospital Based |
| Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan) |
| Freestanding |
| Hospital Based |

Outpatient Lab and Pathology

| |
|----------------|
| Freestanding |
| Hospital Based |

Other Medical Services

| |
|---------------------------------------|
| Spinal Manipulations (20 visits/year) |
| Acupuncture (18 visits/year) |
| Standard Injectables |
| Allergy Injections |
| Biotech/Specialty Injectables |
| Home/Office |
| Outpatient |
| Chemotherapy |
| Dialysis |

Referred

| |
|----------------------------|
| \$250 no deductible |
| No charge after deductible |
| No charge after deductible |

Referred

| |
|----------------------------------|
| \$250/Admission after deductible |
| \$200 after deductible |
| \$250/Admission after deductible |
| No charge after deductible |

Referred

| |
|----------------------------|
| \$100 after deductible |
| \$100 after deductible |
| No charge after deductible |

Referred

| |
|--------------------|
| \$20 no deductible |
| \$20 no deductible |
| \$20 no deductible |
| \$40 no deductible |
| \$40 no deductible |

Referred

| |
|-------------------------|
| No charge no deductible |
| \$40 no deductible |

Referred

| |
|----------------------------|
| \$40 no deductible |
| \$40 no deductible |
| No charge no deductible |
| No charge no deductible |
| No charge after deductible |
| No charge after deductible |
| No charge no deductible |
| No charge no deductible |

Out-of-Network

| |
|-----------------------------|
| Covered at In-Network level |
| Covered at In-Network level |
| Not covered |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |
| Not covered |
| Not covered |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |
| Not covered |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |

Out-of-Network

| |
|-------------|
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |
| Not covered |

| | | |
|--|----------------------------------|-------------|
| Skilled Nursing Facility (120 days/year) | \$250/Admission after deductible | Not covered |
| Home Health | No charge after deductible | Not covered |
| Hospice | No charge no deductible | Not covered |
| Durable Medical Equipment (DME) | 30% after deductible | Not covered |
| Mental Health – Outpatient (includes serious mental illness and substance abuse) | | |
| Office Visit | \$20 no deductible | Not covered |
| All Other Services | \$20 no deductible | Not covered |
| Mental Health – Inpatient (includes serious mental illness and substance abuse) | \$250/Admission after deductible | Not covered |
| Routine Eye Care | \$40 no deductible | Not covered |

- 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, Occupational Therapy, and Cognitive Therapy combined visit limit.

Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

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 Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com

Vision Benefit Highlights

\$100 Eyewear Benefit Annual Benefit

| Covered Services | Your Costs (You pay) | |
|---|-------------------------------|-----------------------------------|
| Benefits | In-Network¹ | 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-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Contract Year | 1 / Contract Year |
| Routine Eye Exam at Davis Participating Providers | \$20 | \$50 Reimbursement |
| Lenses | In-Network¹ | Out-of-Network² |
| Benefit Frequency | 1 / Contract Year | 1 / Contract Year |
| Single Vision Lenses | No charge | \$100 Reimbursement ³ |
| Bifocal Lenses | No charge | \$100 Reimbursement ³ |
| Trifocal Lenses | No charge | \$100 Reimbursement ³ |
| Lenticular Lenses | No charge | \$100 Reimbursement ³ |
| Lens Options ⁴ | | |
| Standard Progressive Lenses | \$50 | Not covered |
| Premium Progressive Lenses | \$90 | Not covered |
| Ultra Progressive Lenses | \$140 | Not covered |
| Ultimate Progressive Lenses | \$175 | \$60 Reimbursement |
| Polycarbonate Lenses - Single Vision ⁵ | \$30 | Not applicable |
| Polycarbonate Lenses - Multifocal Vision | \$30 | Not applicable |
| Photosensitive Lenses - Single Vision | \$60 | Not applicable |
| Photosensitive Lenses - Multifocal Vision | \$70 | Not applicable |
| High-Index Lenses | \$55 | Not applicable |
| High-Index 1.74 Lenses | \$120 | Not applicable |
| Blue Light Lenses | \$15 | Not applicable |
| Polarized Lenses | \$60 | Not applicable |
| Lens Coatings | | |
| Tinted Plastic Lenses | No charge | Not applicable |
| UV-Coated Lenses | \$12 | Not applicable |
| Scratch-Resistant Coating Single-Vision Lenses | \$15 | Not applicable |
| Scratch-Resistant Coating Multifocal Lenses | \$25 | Not applicable |
| Scratch-Protection Plan Single Vision Lenses | Not covered | Not applicable |
| Scratch-Protection Plan Multifocal Vision Lenses | Not covered | Not applicable |
| Anti-Reflective Standard Lenses | \$33 | Not applicable |
| Anti-Reflective Premium Lenses | \$48 | Not applicable |

| | | |
|---|---|----------------------------------|
| Anti-Reflective Ultra Lenses | \$60 | Not applicable |
| Anti-Reflective Ultimate Lenses | \$85 | Not applicable |
| Frames | In-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Contract Year | 1 / Contract Year |
| Davis Collection Fashion Frames | No charge | Not applicable |
| Davis Collection Designer Frames | No charge | Not applicable |
| Davis Collection Premier Frames | No charge | Not applicable |
| Non-Davis Collection Frames | Up to \$65 Allowance (plus a 20% discount on average) ⁶ | \$100 Reimbursement ³ |
| Visionworks Frames Option | Up to \$65 Allowance (plus a 20% discount on average) ⁶ | Not applicable |
| Contact Lenses (in lieu of glasses) | In-Network¹ | Out-of-Network |
| Benefit Frequency | 1 / Contract Year | 1 / Contract Year |
| Davis Collection Standard Daily Contact Lenses & Evaluation | Not covered | Not applicable |
| Davis Collection Specialty Contact Lenses & Evaluation | Not covered | Not applicable |
| Davis Collection Disposable Contact Lenses & Evaluation | Not covered | Not applicable |
| Non-Davis Collection Contact Lenses & Evaluation | Contacts: Up to \$100 Allowance; Evaluation: Not covered; (plus a 15% discount on average) ⁶ | \$100 Reimbursement |
| Medically-Necessary Contact Lenses ⁷ | Not covered | Not covered |

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 Combined cost share.

⁴ Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

⁵ Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

⁶ Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

⁷ 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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجاناً لضمان وصول المعلومات إليك بصيغ ميسرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意: 如果您说普通话, 我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务, 确保以无障碍格式传递信息。请致电 1-800-275-2583 (TTY: 711) 或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksèsib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ्त में उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yánílti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjí' bee adahodooníí diné bich'í' anídahazt'í'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaígíí áldó' t'áá jiik'eh hóló. Kohjí' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'í' hanidziih.

Pennsilfaanisch-Deutsch: WICHDICH: Wann du Deutsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్ కు కాల్ చేయండి లేదా మీ ప్రొవైడర్ తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí ó bá nso Yorùbá, àwọn isẹ̀ àtilẹ̀hin èdè lófẹ̀ẹ̀ wà lárọ̀wọ̀tó rẹ. Àwọn isẹ̀ àtilẹ̀hin irànlọ̀wọ̀ tó yẹ láti pèsè iwífúnni ní ọ̀nà irááyèsì kíkà wà lárọ̀wọ̀tó bakanna lófẹ̀ẹ̀. Pẹ 1-800-275-2583 (TTY: 711) tàbí kí ó bá olùpèsè rẹ sọrọ.

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:

civilrightscoordinator@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.