Independence

# Medical Benefit Highlights

## Personal Choice HDHP HD1-HC1 Swarthmore College

| Covered Services | Your Costs (You pay) | |
|---|---|---|
| **Benefits per Contract Year** | **In-Network** | **Out-of-Network** |
| Deductible (Aggregate)[1] Individual/Family | $2,000/$4,000 | |
| Out-of-Pocket Maximum (Embedded)[2] Individual/Family | $5,600/$11,200 | |
| Coinsurance | 0% | 20% |
| **Preventive Services** | **In-Network** | **Out-of-Network** |
| Preventive Care | No charge no deductible | 20% no deductible |
| Nutritional Counseling (6 visits/year) | No charge no deductible | 20% after deductible |
| Preventive Colonoscopy | | |
| Preventive Plus Providers | No charge no deductible | Not covered |
| Hospital Based | No charge no deductible | 20% no deductible |
| **Physician Services** | **In-Network** | **Out-of-Network** |
| Primary Care Physician (PCP) | | |
| Office Visit | No charge after deductible | 20% after deductible |
| Telemedicine Visit | No charge after deductible | 20% after deductible |
| Specialist | | |
| Office Visit | No charge after deductible | 20% after deductible |
| Telemedicine Visit | No charge after deductible | 20% after deductible |
| Retail Health Clinic Visit | No charge after deductible | 20% after deductible |
| Urgent Care Visit | No charge after deductible | 20% after deductible |
| **Virtual Care**[3](through Teladoc®) | **In-Network** | **Out-of-Network** |
| Telemedicine | No charge after deductible | Not covered |
| Teledermatology | No charge after deductible | Not covered |
| Telebehavioral Health | No charge after deductible | Not covered |
| **Therapy Services** | **In-Network** | **Out-of-Network** |
| Physical Therapy (60 visits/year)[4] | | |
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |
| Occupational Therapy (60 visits/year)[4] | | |
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |
| Speech Therapy (60 visits/year)[5] | No charge after deductible | 20% after deductible |
| **Emergency Services** | **In-Network** | **Out-of-Network** |
| Emergency Room | No charge after deductible | Covered at In-Network level |
| Emergency Ambulance | No charge after deductible | Covered at In-Network level |
| Non-Emergency Ambulance | No charge after deductible | 20% after deductible |
| **Hospital Services** | **In-Network** | **Out-of-Network** |
| Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6] | No charge after deductible | 20% after deductible |

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| Observation Services | No charge after deductible | 20% after deductible |
|---|---|---|
| Maternity Hospital Services[6] | No charge after deductible | 20% after deductible |
| Inpatient Professional Services (includes Maternity) | No charge after deductible | 20% after deductible |

| **Outpatient Surgery** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |
| Outpatient Professional Services | No charge after deductible | 20% after deductible |

| **Outpatient Diagnostics** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Diagnostic Medical (EKG) | No charge after deductible | 20% after deductible |
| Routine Radiology (X-Ray) | | |
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |
| Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan) | | |
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |

| **Outpatient Lab and Pathology** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Freestanding | No charge after deductible | 20% after deductible |
| Hospital Based | No charge after deductible | 20% after deductible |

| **Other Medical Services** | **In-Network** | **Out-of-Network** |
|---|---|---|
| Spinal Manipulations (20 visits/year)[5] | No charge after deductible | 20% after deductible |
| Acupuncture (18 visits/year)[5] | No charge after deductible | 20% after deductible |
| Standard Injectables | No charge after deductible | 20% after deductible |
| Allergy Injections | No charge after deductible | 20% after deductible |
| Biotech/Specialty Injectables | | |
| Home/Office | No charge after deductible | 20% after deductible |
| Outpatient | No charge after deductible | 20% after deductible |
| Chemotherapy | No charge after deductible | 20% after deductible |
| Dialysis | No charge after deductible | 20% after deductible |
| Skilled Nursing Facility (180 days/year)[5] | No charge after deductible | 20% after deductible |
| Home Health | No charge after deductible | 20% after deductible |
| Hospice | No charge after deductible | 20% after deductible |
| Durable Medical Equipment (DME) | No charge after deductible | 20% after deductible |
| Mental Health – Outpatient (includes serious mental illness and substance abuse) | | |
| Office Visit | No charge after deductible | 20% after deductible |
| All Other Services | No charge after deductible | 20% after deductible |
| Mental Health – Inpatient (includes serious mental illness and substance abuse)[6] | No charge after deductible | 20% after deductible |

1 Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.

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](www.ibx.com/findcarenow).

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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.

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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**

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# Drug Benefit Highlights

## HDHP Rx Swarthmore College

| Covered Services | Your Costs (You pay) | |
|---|---|---|
| **Benefits per Contract Year** | **In-Network** | **Out-of-Network** |
| Deductible | Medical deductible applies. | Medical deductible applies. |
| Out-of-Pocket Maximum | Combined with Medical | Combined with Medical |
| Formulary | Select | |

| Retail Pharmacy | In-Network | Out-of-Network |
|---|---|---|
| Tier 1 Generic Drugs | $10 after deductible | 50% Reimbursement after deductible |
| Tier 2 Preferred Brand Drugs | $25 after deductible | 50% Reimbursement after deductible |
| Tier 3 Non-Preferred Drugs | $45 after deductible | 50% Reimbursement after deductible |
| Dispensing Limits[1] | 30 day supply max | 30 day supply max |

| Mail Order Pharmacy<br>Available for maintenance drugs | In-Network | Out-of-Network |
|---|---|---|
| Tier 1 Generic Drugs | $20 after deductible | Not covered |
| Tier 2 Preferred Brand Drugs | $50 after deductible | Not covered |
| Tier 3 Non-Preferred Drugs | $90 after deductible | Not covered |
| Dispensing Limits | 90 day supply max | Not covered |

| Drug Coverage | In-Network | Out-of-Network |
|---|---|---|
| ACA Preventive Drugs[2] | 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 after deductible) | Covered | Covered |
| Injectable Fertility Drugs | Covered | Covered |
| Insulin | Covered | Covered |
| Insulin Needles and Syringes | Covered | Covered |
| Lancets (no copayment/coinsurance required at participating pharmacies after deductible) | Covered | Covered |
| Prescribed Tobacco Cessation Drugs (RX and OTC) | Covered | Covered |
| Allergy Serum | Not covered | Not covered |
| Blood, Blood Plasma | Not covered | Not covered |
| Drugs used for Cosmetic Purposes | 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 90 day supply for maintenance drugs available at retail.

2 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).

Your program includes the HDHP Preventive Enhancement benefit for a defined list of drugs. For the drugs on the preventive drug list, the deductible does not apply and you are only responsible for paying the copayment or coinsurance.

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**