Independence

Medical Benefit Highlights

Swarthmore College Keystone 15 HMO

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**Referred**	**Out-of-Network**
Deductible Individual/Family	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/Family	$1,000/$2,000	Not covered
Coinsurance	0%	Not covered
Preventive Services	**Referred**	**Out-of-Network**
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Nutritional Counseling (6 visits/year)	No charge	Not covered
Physician Services	**Referred**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	$15	Not covered
Specialist Office Visit	$25	Not covered
Retail Health Clinic Visit	$15	Not covered
Urgent Care Visit	$105	Not covered
Virtual Care[2] (Through Teladoc®)	**Referred**	**Out-of-Network**
Telemedicine	$5	Not covered
Teledermatology	$15	Not covered
Telebehavioral Health	$15	Not covered
Therapy Services	**Referred**	**Out-of-Network**
Physical Therapy (60 consecutive days/ year)[3]		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Occupational Therapy (60 consecutive days/year)[3]		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Speech Therapy (60 consecutive days/ year)[3]	No charge	Not covered
Emergency Services	**Referred**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$150	Covered at In-Network level

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Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	Not covered

Hospital Services	Referred	Out-of-Network
Inpatient Hospital Services	$100/Day; max of 5 copays per admission	Not covered
Observation Services (copay waived if admitted)	$150	Not covered
Maternity Hospital Services	$100/Day; max of 5 copays per admission	Not covered
Inpatient Professional Services (includes Maternity)	No charge	Not covered

Outpatient Surgery	Referred	Out-of-Network
Freestanding	$50	Not covered
Hospital Based	$50	Not covered
Outpatient Professional Services	No charge	Not covered

Outpatient Diagnostics	Referred	Out-of-Network
Diagnostic Medical (EKG)	No charge	Not covered
Routine Radiology (X-Ray)		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered

Outpatient Lab and Pathology	Referred	Out-of-Network
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered

Other Medical Services	Referred	Out-of-Network
Spinal Manipulations (60 visits/year)	No charge	Not covered
Acupuncture (18 visits/year)	$25	Not covered
Standard Injectables	No charge	Not covered
Allergy Injections	No charge	Not covered
Biotech/Specialty Injectables		
Home/Office	No charge	Not covered
Outpatient	No charge	Not covered
Chemotherapy	No charge	Not covered
Dialysis	No charge	Not covered
Skilled Nursing Facility (180 days/year)	No charge	Not covered
Home Health	No charge	Not covered

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Hospice	No charge	Not covered
Durable Medical Equipment (DME)	No charge	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$25	Not covered
All Other Services	No charge	Not covered
Mental Health – Inpatient (includes serious mental illness and substance abuse)	$100/Day; max of 5 copays per admission	Not covered
Routine Eye Care	$25	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.

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

3 Physical Therapy, Occupational Therapy, and Speech 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/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 Keystone Health Plan East, 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

Swarthmore College Select Rx $15/$35/$50 Keystone

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	$0/$0
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Formulary	Select	

Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$15	30% Reimbursement
Tier 2 Preferred Brand Drugs	$35	30% Reimbursement
Tier 3 Non-Preferred Drugs	$50	30% Reimbursement
Dispensing Limits[1]	30 day supply max	30 day supply max

Mail Order Pharmacy **Available for maintenance drugs**	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	$30	Not covered
Tier 2 Preferred Brand Drugs	$70	Not covered
Tier 3 Non-Preferred Drugs	$100	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)	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies)	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
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

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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).

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.

Referred benefits are underwritten or administered by Keystone Health Plan East; Self-Referred benefits are underwritten by QCC Insurance company, subsidiaries of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**