

Medical Benefit Highlights

Swarthmore College PPO 25/40/150

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	In-Network	Out-of-Network
Deductible (Embedded) ¹ Individual/Family	\$0/\$0	\$500/\$1,000
Out-of-Pocket Maximum (Embedded) ² Individual/Family	\$1,500/\$3,000	\$3,000/\$6,000
Coinsurance	0%	30%
Preventive Services		
Preventive Care	No charge	30% no deductible
Nutritional Counseling (6 visits/year)	No charge	30% after deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	30% no deductible
Physician Services		
Primary Care Physician (PCP)		
Office Visit	\$25	30% after deductible
Telemedicine Visit	\$25	30% after deductible
Specialist		
Office Visit	\$40	30% after deductible
Telemedicine Visit	\$40	30% after deductible
Retail Health Clinic Visit	\$25	30% after deductible
Urgent Care Visit	\$105	30% after deductible
Virtual Care³(through Teladoc®)		
Telemedicine	\$5	Not covered
Teledermatology	\$15	Not covered
Telebehavioral Health	\$15	Not covered
Therapy Services		
Physical Therapy (60 visits/year) ⁴		
Freestanding	Visits 1-30: \$25 Visits 31+: \$40	30% after deductible
Hospital Based	Visits 1-30: \$25 Visits 31+: \$40	30% after deductible
Occupational Therapy (60 visits/year) ⁴		
Freestanding	Visits 1-30: \$25 Visits 31+: \$40	30% after deductible
Hospital Based	Visits 1-30: \$25 Visits 31+: \$40	30% after deductible
Speech Therapy (60 visits/year) ⁴	Visits 1-30: \$25 Visits 31+: \$40	30% after deductible
Emergency Services		
Emergency Room (copay waived if admitted)	\$150	Covered at In-Network level
Emergency Ambulance	No charge	Covered at In-Network level
Non-Emergency Ambulance	No charge	30% after deductible

Hospital Services

Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)⁵

Observation Services (copay waived if admitted)

Maternity Hospital Services⁵

Inpatient Professional Services (includes Maternity)

In-Network

\$150/Day; max of 5 copays per admission

\$150

\$150/Day; max of 5 copays per admission

No charge

Out-of-Network

30% after deductible

30% after deductible

30% after deductible

30% after deductible

Outpatient Surgery

Freestanding

Hospital Based

Outpatient Professional Services

In-Network

\$150

\$150

No charge

Out-of-Network

30% after deductible

30% after deductible

30% after deductible

Outpatient Diagnostics

Diagnostic Medical (EKG)

Routine Radiology (X-Ray)

Freestanding

Hospital Based

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

Freestanding

Hospital Based

In-Network

\$40

\$40

\$40

\$40

\$40

Out-of-Network

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

Outpatient Lab and Pathology

Freestanding

Hospital Based

In-Network

No charge

No charge

Out-of-Network

30% after deductible

30% after deductible

Other Medical Services

Spinal Manipulations (30 visits/year)⁶

Acupuncture (18 visits/year)⁶

Standard Injectables

Allergy Injections

Biotech/Specialty Injectables

Home/Office

Outpatient

Chemotherapy

Dialysis

Skilled Nursing Facility (180 days/year)⁶

Home Health

Hospice (14 days/year)⁶

Durable Medical Equipment (DME)

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

Office Visit

All Other Services

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

In-Network

\$40

\$40

No charge

No charge

No charge

No charge

No charge

No charge

No charge

No charge

No charge

\$40

\$40

\$40

\$150/Day; max of 5 copays per admission

Out-of-Network

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

30% after deductible

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30% after deductible

30% after deductible

30% after deductible

- 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, Speech Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
 - 5 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
 - 6 Combined in and out-of-network.
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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

Drug Benefit Highlights

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

Covered Services

Benefits per Calendar Year

Deductible

Out-of-Pocket Maximum

Formulary

Retail Pharmacy

Tier 1 Generic Drugs

Tier 2 Preferred Brand Drugs

Tier 3 Non-Preferred Drugs

Dispensing Limits¹

Mail Order Pharmacy Available for maintenance drugs

Tier 1 Generic Drugs

Tier 2 Preferred Brand Drugs

Tier 3 Non-Preferred Drugs

Dispensing Limits

Drug Coverage

ACA Preventive Drugs²

Compound Medications

Contraceptives

Diabetic Supplies (i.e., test strips)

Glucometers (no copayment/coinsurance required at participating pharmacies)

Insulin

Insulin Needles and Syringes

Lancets (no copayment/coinsurance required at participating pharmacies)

Prescribed Tobacco Cessation Drugs (RX and OTC)

Allergy Serum

Blood, Blood Plasma

Drugs used for Cosmetic Purposes

Injectable Fertility Drugs

Investigational/Experimental Drugs

Non-Federal Legend Drugs

Over-The-Counter Drugs (Non-Prescription)

Weight Control Drugs

Your Costs (You pay)

In-Network

\$0/\$0

Combined with Medical
Select

In-Network

\$15

\$35

\$50

30 day supply max

In-Network

\$30

\$70

\$100

90 day supply max

In-Network

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Out-of-Network

\$0/\$0

Combined with Medical

Out-of-Network

30% Reimbursement

30% Reimbursement

30% Reimbursement

30 day supply max

Out-of-Network

Not covered

Not covered

Not covered

Not covered

Out-of-Network

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

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.
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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.

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