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[4]	$5,600/$11,200	
Coinsurance	0%	20%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	20% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	20% no deductible
Nutrition Counseling (6 visits per year)[4]	No charge no deductible	20% after deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	No charge after deductible	20% after deductible
Specialist Office Visit	No charge after deductible	20% after deductible
Retail Health Clinic Visit	No charge after deductible	20% after deductible
Telemedicine (through MDLive®)	No charge after deductible	Not covered
Urgent Care Visit	No charge after deductible	20% after deductible
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[3]		
Freestanding	No charge after deductible	20% after deductible
Hospital Based	No charge after deductible	20% after deductible
Occupational Therapy (60 visits/year)[3]		
Freestanding	No charge after deductible	20% after deductible
Hospital Based	No charge after deductible	20% after deductible
Speech Therapy (60 visits/year)[4]	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)[5]	No charge after deductible	20% after deductible
Observation Services	No charge after deductible	20% after deductible
Maternity Hospital Services[5]	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

Reference ID: 1003495101012020

Independence

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)[4]	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)[4]	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)	No charge after deductible	20% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[5]	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] Physical Therapy and Occupational Therapy combined visit limit in and out of network.

[4] Combined 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.

Independence

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**

Reference ID: 1003495101012020

Independence

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	$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 **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	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
Injectable Fertility Drugs	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
Retin-A (up to Age 35)	Covered	Covered
Allergy Serum	Not covered	Not covered
Biologicals, Investigational/Experimental Drugs	Not covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Immunization Agents	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] Maintenance medications may also be available for up to a 90-day supply at participating Act 207 Retail pharmacies for the same mail order member cost sharing as indicated above.

Independence

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).

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.

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. Drugs used to treat hemophilia are not covered.

All covered self-administered specialty medications except insulin 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.

FutureScripts® 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. FutureScripts® is an independent company providing pharmacy benefit management service.
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**