## Medical Benefit Highlights

**Personal Choice HDHP HD1-HC1 Swarthmore College**

### Covered Services

<table>
<thead>
<tr>
<th>Benefits per Contract Year</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Aggregate)&lt;sup&gt;1&lt;/sup&gt; Individual/Family</td>
<td>$2,000</td>
<td>$5,600</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Embedded)&lt;sup&gt;2&lt;/sup&gt; Individual/Family&lt;sup&gt;4&lt;/sup&gt;</td>
<td>$4,000</td>
<td>$11,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Preventive Services

- Preventive Care
- Preventive Colonoscopy
- Preventive Plus Providers
- Hospital Based
- Nutrition Counseling (6 visits per year)<sup>4</sup>

### Physician Services

- Primary Care Physician (PCP) Office Visit
- Specialist Office Visit
- Retail Health Clinic Visit
- Telemedicine (through MDLive®)
- Urgent Care Visit

### Therapy Services

- Physical Therapy (60 visits/year)<sup>3</sup>
  - Freestanding
  - Hospital Based
- Occupational Therapy (60 visits/year)<sup>3</sup>
  - Freestanding
  - Hospital Based
- Speech Therapy (60 visits/year)<sup>4</sup>

### Emergency Services

- Emergency Room
- Emergency Ambulance
- Non-Emergency Ambulance

### Hospital Services

- Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)<sup>5</sup>
- Observation Services
- Maternity Hospital Services<sup>5</sup>
- Inpatient Professional Services (includes Maternity)

### Outpatient Surgery

- Freestanding

### Your Costs (You pay)

- **In-Network**
  - No charge after deductible
  - No charge after deductible
  - No charge after deductible
  - No charge after deductible

- **Out-of-Network**
  - Covered at In-Network level
  - Covered at In-Network level
  - 20% after deductible

Reference ID: 1003495101012020
<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Diagnostics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Medical (EKG)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Routine Radiology (X-Ray)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient Lab and Pathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Other Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulations (20 visits/year)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Standard Injectables</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Home/Office</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (180 days/year)&lt;sup&gt;4&lt;/sup&gt;</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Home Health</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>No charge after deductible</td>
<td></td>
</tr>
<tr>
<td>Mental Health – Outpatient (includes serious mental illness and substance abuse)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Mental Health – Inpatient (includes serious mental illness and substance abuse)&lt;sup&gt;5&lt;/sup&gt;</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

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.


5. Inpatient hospital out of network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.
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

**HDHP Rx Swarthmore College**

## Covered Services

<table>
<thead>
<tr>
<th>Benefits per Contract Year</th>
<th>Your Costs (You pay)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Medical deductible applies.</td>
<td>Medical deductible applies.</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Combined with Medical Select</td>
<td>Combined with Medical Select</td>
</tr>
<tr>
<td>Formulary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Retail Pharmacy

<table>
<thead>
<tr>
<th>Tier 1 Generic Drugs</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 after deductible</td>
<td></td>
<td>50% Reimbursement after deductible</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$25 after deductible</td>
<td>50% Reimbursement after deductible</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$45 after deductible</td>
<td>50% Reimbursement after deductible</td>
</tr>
</tbody>
</table>

### Dispensing Limits

- 30 day supply max

### Mail Order Pharmacy

**Available for maintenance drugs**

<table>
<thead>
<tr>
<th>Tier 1 Generic Drugs</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 after deductible</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$50 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$90 after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>90 day supply max</td>
<td></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Drug Coverage

- ACA Preventive Drugs
- Compound Medications
- Contraceptives
- Diabetic Supplies (i.e., test strips)
- Glucometers (no copayment/coinsurance required at participating pharmacies)
- Injectable Fertility Drugs
- Insulin
- Insulin Needles and Syringes
- Lancets (no copayment/coinsurance required at participating pharmacies)
- Prescribed Tobacco Cessation Drugs (RX and OTC)
- Retin-A (up to Age 35)
- Allergy Serum
- Biologicals, Investigational/Experimental Drugs
- Blood, Blood Plasma
- Drugs used for Cosmetic Purposes
- Immunization Agents
- Non-Federal Legend Drugs
- Over-The-Counter Drugs (Non-Prescription)
- Weight Control Drugs

### Dispensing Limits

- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
- Covered
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- Not covered
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- Not covered
- 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.

Reference ID: 1003494701012020
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