## 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)² ¹</td>
<td>$2,000/$4,000</td>
<td>$5,600/$11,200</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Embedded)² ¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Services

- **Preventive Care**
  - Preventive Colonoscopy
    - Preventive Plus Providers
    - Hospital Based
- Nutritional Counseling (6 visits/year)

### Physician Services

- **Primary Care Physician (PCP) Office Visit**
  - Office Visit
  - Telemedicine Visit
- **Specialist Office Visit**
  - Office Visit
  - Telemedicine Visit
  - Retail Health Clinic Visit
  - Urgent Care Visit

### Virtual Care³

- Telemedicine (through MDLive®)
- Teledermatology
- Telebehavioral Health

### Therapy Services

- **Physical Therapy (60 visits/year)⁴**
  - Freestanding
  - Hospital Based
- **Occupational Therapy (60 visits/year)⁴**
  - Freestanding
  - Hospital Based
- **Speech Therapy (60 visits/year)⁵**

### 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)⁶

### Your Costs (You pay)

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Preventive Colonoscopy

- Preventive Plus Providers
- Hospital Based

### Nutritional Counseling (6 visits/year)

- Intr-Network
- Out-of-Network

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<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

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### Your Costs (You pay)

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<thead>
<tr>
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<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

Reference ID: 10045143PS01012022
<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Services</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Maternity Hospital Services(^6)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Inpatient Professional Services (includes Maternity)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>In-Network</td>
<td>Out-of-Network</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 Professional Services</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient Diagnostics</td>
<td>In-Network</td>
<td>Out-of-Network</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>In-Network</td>
<td>Out-of-Network</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>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Spinal Manipulations (20 visits/year)(^5)</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Acupuncture (18 visits/year)(^5)</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>20% after deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Home/Office</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility (180 days/year)(^5)</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>20% after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>No charge after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>No charge after deductible</td>
<td>20% after deductible</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)(^6)</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. **Telemedicine** is provided by a designated telemedicine provider, please visit [www.ibx.com/findcarenow](http://www.ibx.com/findcarenow).

4. **Physical Therapy and Occupational Therapy combined visit limit in and out-of-network.**

5. **Combined in and out-of-network.**
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>In-Network</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>Medical deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$25 after deductible</td>
<td>$25 after deductible</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$45 after deductible</td>
<td>$45 after deductible</td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>30 day supply max</td>
<td>30 day supply max</td>
</tr>
</tbody>
</table>

### 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>Medical deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 Preferred Brand Drugs</td>
<td>$50 after deductible</td>
<td>$50 after deductible</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$90 after deductible</td>
<td>$90 after deductible</td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>90 day supply max</td>
<td>90 day supply max</td>
</tr>
</tbody>
</table>

### Drug Coverage

- **ACA Preventive Drugs**
  - Covered
- **Compound Medications**
  - Covered
- **Contraceptives**
  - Covered
- **Diabetic Supplies (i.e., test strips)**
  - Covered
- **Glucometers (no copayment/coinsurance required at participating pharmacies after deductible)**
  - Covered
- **Injectable Fertility Drugs**
  - Covered
- **Insulin**
  - Covered
- **Insulin Needles and Syringes**
  - Covered
- **Lancets (no copayment/coinsurance required at participating pharmacies after deductible)**
  - Covered
- **Prescribed Tobacco Cessation Drugs (RX and OTC)**
  - Covered
- **Retin-A (up to Age 35)**
  - Covered
- **Allergy Serum**
  - Covered
- **Biologicals, Investigational/Experimental Drugs**
  - Not covered
- **Blood, Blood Plasma**
  - Not covered
- **Drugs used for Cosmetic Purposes**
  - Not covered

Reference ID: 1003494701012020
<table>
<thead>
<tr>
<th>Category</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization Agents</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-Federal Legend Drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td>Over-The-Counter Drugs (Non-Prescription)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Weight Control Drugs</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

1 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](http://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. 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](http://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](http://www.ibx.com)
Language Assistance Services


Chinese: 注意：如果您讲中文，您得到免费的语言协助服务。致电 1-800-275-2583。


Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: તમે કોઇપણ ગુજરાતી બોલતા હો, તો નીચેના લાંબા સંખ્યા સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.


Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجاني. اتصل برقم 2583-800-1.


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।


Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi): تووجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌شود. با شماره 1-800-275-2583 تماس بگیرید.


Urdu: 
تووجه: اگر آپ اردو بولتے ہیں، تو آپ کے لئے مفت میں اردو معاون خدمات دریافت کر سکتے ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: ក្រុមជីេនជាតិខ្មែរគ្រប់គ្រាន់ប្រកួតប្រជាញង់ប្រភេទនេះ ត្រូវបានស្វែងរកឲ្យសម្រាប់ប្រកួតប្រជាញង់ក្នុងស្ថានភាពអំពីវាដោយសារប្រព័្័ពង្សស ក្នុងស្ថានភាពដូច្នេះ 1-800-275-2583។

Y0041_HM_17_47643 Accepted 10/14/2016 Taglines as of 10/14/2016
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.