Independence

Medical Benefit Highlights

Personal Choice BASIC HDHP

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual/Family	$3,300/$6,600	
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$5,600/$11,200	
Coinsurance	10%	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
Nutritional Counseling (6 visits/year)	No charge no deductible	20% after deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	10% after deductible	20% after deductible
Telemedicine Visit	10% after deductible	20% after deductible
Specialist		
Office Visit	10% after deductible	20% after deductible
Telemedicine Visit	10% after deductible	20% after deductible
Retail Health Clinic Visit	10% after deductible	20% after deductible
Urgent Care Visit	10% after deductible	20% after deductible
Virtual Care[3] (Through Teladoc®)	**In-Network**	**Out-of-Network**
Telemedicine	10% after deductible	Not covered
Teledermatology	10% after deductible	Not covered
Telebehavioral Health	10% after deductible	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]		
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible
Occupational Therapy (60 visits/year)[4]		
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible
Speech Therapy (60 visits/year)[5]	10% after deductible	20% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room	10% after deductible	Covered at In-Network level
Emergency Ambulance	10% after deductible	Covered at In-Network level
Non-Emergency Ambulance	10% 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)[6]	10% after deductible	20% after deductible

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Observation Services	10% after deductible	20% after deductible
Maternity Hospital Services[6]	10% after deductible	20% after deductible
Inpatient Professional Services (includes Maternity)	10% after deductible	20% after deductible

Outpatient Surgery	**In-Network**	**Out-of-Network**
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible
Outpatient Professional Services	10% after deductible	20% after deductible

Outpatient Diagnostics	**In-Network**	**Out-of-Network**
Diagnostic Medical (EKG)	10% after deductible	20% after deductible
Routine Radiology (X-Ray)		
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible

Outpatient Lab and Pathology	**In-Network**	**Out-of-Network**
Freestanding	10% after deductible	20% after deductible
Hospital Based	10% after deductible	20% after deductible

Other Medical Services	**In-Network**	**Out-of-Network**
Spinal Manipulations (20 visits/year)[5]	10% after deductible	20% after deductible
Acupuncture (18 visits/year)[5]	10% after deductible	20% after deductible
Standard Injectables	10% after deductible	20% after deductible
Allergy Injections	10% after deductible	20% after deductible
Biotech/Specialty Injectables		
Home/Office	10% after deductible	20% after deductible
Outpatient	10% after deductible	20% after deductible
Chemotherapy	10% after deductible	20% after deductible
Dialysis	10% after deductible	20% after deductible
Skilled Nursing Facility (180 days/year)[5]	10% after deductible	20% after deductible
Home Health	10% after deductible	20% after deductible
Hospice	10% after deductible	20% after deductible
Durable Medical Equipment (DME)	10% after deductible	20% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	10% after deductible	20% after deductible
All Other Services	10% after deductible	20% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	10% after deductible	20% 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**.

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

5 Combined in and out-of-network.

6 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**

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Drug Benefit Highlights

Basic 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 Drugs	$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[1]	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 after deductible)	Covered	Covered
Injectable Fertility Drugs	Covered	Covered
Insulin	Covered	Covered
Insulin Needles and Syringes	Covered	Covered
Lancets (no copayment/coinsurance required at participating pharmacies after deductible)	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
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

1 90-day supply of 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).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

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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