

Medical Benefit Highlights

Swarthmore College Keystone 15 HMO

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	Referred	Out-of-Network
Deductible		
Individual/Family	\$0/\$0	Not covered
Out-of-Pocket Maximum (Embedded) ¹		
Individual/Family	\$1,000/\$2,000	Not covered
Coinsurance	0%	Not covered
Preventive Services	Referred	Out-of-Network
Preventive Care	No charge	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge	Not covered
Hospital Based	No charge	Not covered
Nutritional Counseling (6 visits/year)	No charge	Not covered
Physician Services	Referred	Out-of-Network
Primary Care Physician (PCP)		
Office Visit	\$15	Not covered
Telemedicine Visit	\$15	Not covered
Specialist		
Office Visit	\$25	Not covered
Telemedicine Visit	\$25	Not covered
Retail Health Clinic Visit	\$15	Not covered
Urgent Care Visit	\$15	Not covered
Virtual Care² (Through Teladoc[®])	Referred	Out-of-Network
Telemedicine	\$5	Not covered
Teledermatology	\$15	Not covered
Telebehavioral Health	\$15	Not covered
Therapy Services	Referred	Out-of-Network
Physical Therapy (60 consecutive days/year) ³		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Occupational Therapy (60 consecutive days/year) ³		
Freestanding	No charge	Not covered
Hospital Based	No charge	Not covered
Speech Therapy (60 consecutive days/year) ³	No charge	Not covered
Emergency Services	Referred	Out-of-Network
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	Not covered

Hospital Services

Inpatient Hospital Services

Observation Services (copay waived if admitted)

Maternity Hospital Services

Inpatient Professional Services (includes Maternity)

Referred

\$100/Day; max of 5 copays per admission

\$150

\$100/Day; max of 5 copays per admission

No charge

Out-of-Network

Not covered

Not covered

Not covered

Not covered

Outpatient Surgery

Freestanding

Hospital Based

Outpatient Professional Services

Referred

\$50

\$50

No charge

Out-of-Network

Not covered

Not covered

Not covered

Outpatient Diagnostics

Diagnostic Medical (EKG)

Routine Radiology (X-Ray)

Freestanding

Hospital Based

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

Freestanding

Hospital Based

Referred

No charge

No charge

No charge

No charge

No charge

Out-of-Network

Not covered

Not covered

Not covered

Not covered

Not covered

Outpatient Lab and Pathology

Freestanding

Hospital Based

Referred

No charge

No charge

Out-of-Network

Not covered

Not covered

Other Medical Services

Spinal Manipulations (60 visits/year)

Acupuncture (18 visits/year)

Standard Injectables

Allergy Injections

Biotech/Specialty Injectables

Home/Office

Outpatient

Chemotherapy

Dialysis

Skilled Nursing Facility (180 days/year)

Home Health

Hospice

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)

Routine Eye Care

Referred

No charge

\$25

No charge

No charge

No charge

No charge

No charge

No charge

No charge

No charge

No charge

No charge

\$25

No charge

\$100/Day; max of 5 copays per admission

No charge

Out-of-Network

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

Not covered

- 1 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.
 - 2 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.
 - 3 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit.
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Keystone is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed. Designated Site – PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

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 Keystone Health Plan East, 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 Keystone

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 Limits ¹

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 Drugs ²
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
Covered
Not 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
Covered
Not 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).

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.

Referred benefits are underwritten or administered by Keystone Health Plan East; Self-Referred benefits are underwritten by QCC Insurance company, subsidiaries of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. www.ibx.com