## Medical Benefit Highlights
### Personal Choice HDHP HD1-HC1 Haverford College

### Covered Services

<table>
<thead>
<tr>
<th>Benefits per Calendar Year</th>
<th>Your Costs (You pay)</th>
<th>Deductible (Aggregate)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Individual/Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (See Footnote)²</td>
<td></td>
<td>Individual/Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Preventive Care</th>
<th>No charge no deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preventive Colonoscopy</td>
<td>No charge no deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive Plus Providers</td>
<td>No charge no deductible</td>
</tr>
<tr>
<td></td>
<td>Hospital Based</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>Primary Care Physician (PCP) Office Visit</th>
<th>No charge after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist Office Visit</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Retail Health Clinic Visit</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Visit</td>
<td>No charge after deductible</td>
</tr>
</tbody>
</table>

### Virtual Care³

<table>
<thead>
<tr>
<th>Telemedicine</th>
<th>No charge after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teledermatology</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Telebehavioral Health</td>
<td>No charge after deductible</td>
</tr>
</tbody>
</table>

### Therapy Services

<table>
<thead>
<tr>
<th>Physical Therapy (60 visits/year)⁴</th>
<th>No charge after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Occupational Therapy (60 visits/year)⁴</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Speech Therapy (60 visits/year)⁵</td>
<td>No charge after deductible</td>
</tr>
</tbody>
</table>

### Emergency Services

<table>
<thead>
<tr>
<th>Emergency Room</th>
<th>No charge after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td>No charge after deductible</td>
</tr>
</tbody>
</table>

## Coverage Details

- **In-Network:**
  - Deductible: $1,500/$3,000
  - Out-of-Pocket Maximum: $6,350/$12,700
  - Coinsurance: 0%

- **Out-of-Network:**
  - Deductible: $5,000/$10,000
  - Out-of-Pocket Maximum: $10,000/$20,000
  - Coinsurance: 50%

### Preventive Care

- Preventive Care:
  - In-Network: No charge no deductible
  - Out-of-Network: No charge no deductible

- Preventive Colonoscopy:
  - In-Network: No charge no deductible
  - Out-of-Network: Not covered

- Preventive Plus Providers:
  - In-Network: No charge no deductible
  - Out-of-Network: Not covered

### Hospital Based

- No charge after deductible

### Physician Services

- Primary Care Physician (PCP) Office Visit:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

- Specialist Office Visit:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

- Retail Health Clinic Visit:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

- Urgent Care Visit:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

### Virtual Care³

- Telemedicine:
  - In-Network: No charge after deductible
  - Out-of-Network: Not covered

- Teledermatology:
  - In-Network: No charge after deductible
  - Out-of-Network: Not covered

- Telebehavioral Health:
  - In-Network: No charge after deductible
  - Out-of-Network: Not covered

### Therapy Services

- Physical Therapy (60 visits/year)⁴:
  - Freestanding:
    - In-Network: No charge after deductible
    - Out-of-Network: 50% after deductible
  - Hospital Based:
    - In-Network: No charge after deductible
    - Out-of-Network: 50% after deductible

- Occupational Therapy (60 visits/year)⁴:
  - Freestanding:
    - In-Network: No charge after deductible
    - Out-of-Network: 50% after deductible
  - Hospital Based:
    - In-Network: No charge after deductible
    - Out-of-Network: 50% after deductible

- Speech Therapy (60 visits/year)⁵:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

### Emergency Services

- Emergency Room:
  - In-Network: No charge after deductible
  - Out-of-Network: Covered at In-Network level

- Emergency Ambulance:
  - In-Network: No charge after deductible
  - Out-of-Network: Covered at In-Network level

- Non-Emergency Ambulance:
  - In-Network: No charge after deductible
  - Out-of-Network: 50% after deductible

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Reference ID: 1004082301012021
### Hospital Services
- Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)<sup>6</sup>
- Observation Services
- Maternity Hospital Services<sup>6</sup>
- Inpatient Professional Services (includes Maternity)

### Outpatient Surgery
- Freestanding
- Hospital Based
- Outpatient Professional Services

### Outpatient Diagnostics
- Diagnostic Medical (EKG)
- Routine Radiology (X-Ray)
- Freestanding
- Hospital Based
- Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)
- Freestanding
- Hospital Based

### Outpatient Lab and Pathology
- Freestanding
- Hospital Based

### Other Medical Services
- Spinal Manipulations (20 visits/year)<sup>5</sup>
- Acupuncture (18 visits/year)<sup>5</sup>
- Standard Injectables
- Allergy Injections
- Biotech/Specialty Injectables
  - Home/Office
  - Outpatient
- Chemotherapy
- Dialysis
- Skilled Nursing Facility (120 days/year)<sup>5</sup>
- Home Health
- Hospice
- Durable Medical Equipment (DME)

### In-Network
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible
- No charge after deductible

### Out-of-Network
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
- 50% after deductible
### Mental Health – Outpatient (includes serious mental illness and substance abuse)
- No charge after deductible
- 50% after deductible

### Mental Health – Inpatient (includes serious mental illness and substance abuse)
- No charge after deductible
- 50% after deductible

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1. Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.

2. In-Network 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. Out-of-Network aggregate out-of-pocket maximum: For family coverage, the entire family out-of-pocket maximum must be met before copayments or coinsurance are applied for an individual member.

3. Telemedicine is provided by a designated telemedicine provider, please visit [www.ibx.com/findcarenow](http://www.ibx.com/findcarenow).

4. Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit 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.

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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](http://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](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](http://www.ibx.com)
## Drug Benefit Highlights

### Personal Choice HDHP HD1-HC1 Haverford College Rx

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Benefits per Calendar Year</th>
<th>Your Costs (You pay)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Formulary</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Retail Pharmacy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic Drugs</td>
<td>$5 after deductible</td>
<td>50% reimbursement after deductible</td>
<td></td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$20 after deductible</td>
<td>50% reimbursement after deductible</td>
<td></td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$45 after deductible</td>
<td>50% reimbursement after deductible</td>
<td></td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>30 day supply max</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy Available for maintenance drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic Drugs</td>
<td>$10 after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 2 Preferred Brand Drugs</td>
<td>$40 after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$90 after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>90 day supply max</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACA Preventive Drugs</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Compound Medications</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies (i.e., test strips)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Glucometers (no copayment/coinsurance required at participating pharmacies after deductible)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin Needles and Syringes</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Lancets (no copayment/coinsurance required at participating pharmacies after deductible)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescribed Tobacco Cessation Drugs (RX and OTC)</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Blood, Blood Plasma</td>
<td>Covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Drugs used for Cosmetic Purposes</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunization Agents</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Injectable Fertility Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Investigational/Experimental Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Reference ID: 1004082801012021
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. Up to a 90-day supply of drugs to treat chronic conditions available at any participating retail pharmacy or mail for same cost share.

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.

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).

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. If your doctor wants you to start the drug immediately, an initial 30-day supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through the Specialty Pharmacy Program.

The pharmacy 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.

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，您可以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: તમે અહીં ગુજરાતી બોલતા હોય તો નિશ્ચિત ભાષા સહાય સેવાઓ ટમરા 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 بالمجان. اتصل برقم 275-2583-800.


Hindi: ध्यान दे: 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): توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌گردد. با شماره 1-800-275-2583 تماس بگیرید.


Urdu: توجه درکاری: اگر اردو زبان بولتے بیں، تو اپنے لئے مفت میں زبان معلومات خدمات دستیاب بیں۔ کال کریں 1-800-275-2583۔

Mon-Khmer, Cambodian: បុគ្គលិកជាតិអង់គ្លេសឬយើងអោយ ចុះដឹកនាំប្រការការនឹងធម្មតារក្នុងរៀបរាប់ ដែលយើងអោយការប្រការនឹងព័ត៌មានប្រការក្នុងអង់គ្លេស។ 1-800-275-2583។

Y0041_HM_17_47643 Accepted 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.