# Medical Benefit Highlights

Keystone Health Plan East HMO Haverford College

## Covered Services

<table>
<thead>
<tr>
<th>Benefits per Calendar Year</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Individual/Family</td>
<td>$0/$0</td>
<td>Not covered</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Embedded) Individual/Family</td>
<td>$6,350/$12,700</td>
<td>Not covered</td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Preventive Services

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Colonoscopy</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive Plus Providers</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Based</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Physician Services

<table>
<thead>
<tr>
<th>Primary Care Physician (PCP)</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telemedicine Visit</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$25</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telemedicine Visit</td>
<td>$25</td>
<td>Not covered</td>
</tr>
<tr>
<td>Retail Health Clinic Visit</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>Urgent Care Visit</td>
<td>$105</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Virtual Care

<table>
<thead>
<tr>
<th>Telemedicine</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teledermatology</td>
<td>$15</td>
<td>Not covered</td>
</tr>
<tr>
<td>Telebehavioral Health</td>
<td>$15</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

## Therapy Services

<table>
<thead>
<tr>
<th>Physical Therapy (60 consecutive days/year)</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Occupational Therapy (60 consecutive days/year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestanding</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Speech Therapy (60 consecutive days/year)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Referred</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Emergency Room (copay waived if admitted)</td>
<td>$150</td>
<td>Covered at In-Network level</td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td>No charge</td>
<td>Covered at In-Network level</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>$500/Admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Observation Services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maternity Hospital Services</td>
<td>$500/Admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient Professional Services (includes Maternity)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Surgery</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>$250</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>$250</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Diagnostics</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Medical (EKG)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Radiology (X-Ray)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Lab and Pathology</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Medical Services</th>
<th>Referred</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulations (60 consecutive days/year)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Acupuncture (18 visits/year)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Standard Injectables</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home/Office</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Service</td>
<td>Charge</td>
<td>Covered Status</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility (180 days/year)</td>
<td>$500/Admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home Health (60 visits/Every 90 Days)</td>
<td>$10</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mental Health – Outpatient (includes serious mental illness and substance abuse)</td>
<td>$25</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mental Health – Inpatient (includes serious mental illness and substance abuse)</td>
<td>$500/Admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine Eye Care</td>
<td>$25</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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](http://www.ibx.com/findcarenow).
3. Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit.

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](http://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](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 Keystone Health Plan East, 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
Select Drug Program $20/$40/$80.. Haverford College

### Covered Services

<table>
<thead>
<tr>
<th>Benefits per Calendar Year</th>
<th>Your Costs (You pay)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0/$0</td>
<td>$0/$0</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Combined with Medical Select</td>
<td>Combined with Medical</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></td>
<td>$20</td>
<td>30% Reimbursement</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$40</td>
<td>30% Reimbursement</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$80</td>
<td>30% Reimbursement</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></td>
<td>$40</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$80</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$160</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>90 day supply max</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Dispensing Limits

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></td>
<td>$40</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand</td>
<td>$80</td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Drugs</td>
<td>$160</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dispensing Limits</td>
<td>90 day supply max</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Drug Coverage

<table>
<thead>
<tr>
<th>ACA Preventive Drugs²</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Compound Medications</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies (i.e., test strips)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Glucometers (no copayment/coinsurance required at participating pharmacies)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Insulin Needles and Syringes</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Lancets (no copayment/coinsurance required at participating pharmacies)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescribed Tobacco Cessation Drugs (RX and OTC)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Blood, Blood Plasma</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Drugs used for Cosmetic Purposes</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Immunization Agents</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Injectable Fertility Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Investigational/Experimental Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-Federal Legend Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Over-The-Counter Drugs (Non-Prescription)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Weight Control Drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Reference ID: 1004082701012021
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 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 by selecting the Find a Participating Pharmacy feature.

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
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: પ્રથમ સ્વપ્ન: માફી કીને, તમે હંમેશા સાથે હોય દેખાશે તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.


Russian: ВНИМАНИЕ: Если вы говорите по-русски, то вы 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 بالجانب. اتصل برقم 800-475-8533.


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाओं 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 می‌شود. با شماره 1-800-275-2583 تماس بگیرید.


Urdu: توجه درکریں: اگر اپنے زبان بولتے بہت، تو آپ کے لیے مفت میں زبان معاون خدمات دستیاب بہت کریں 1-800-275-2583।

Cambodian (Mon-Khmer): ប្រាសាទសំខាន់៖ ប្រការីជីវិតប្រាក់ដឹកជញ្ជូនប្រការីអំពីការជ្រើសរើសការជរៀបចម្រុះ ឬ ប្រការីជ្រើសរើសរបស់អ្នកប្រការីអំពីការជរៀបចម្រុះ ឬ ប្រការីជរៀបចម្រុះ 1-800-275-2583។
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.