

Gettysburg College 1700 QHDHP Benefit Summary

This program is a qualified high-deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

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Physical Medicine Physical Medicine Speech Therapy Speech Therapy Physical Medicine Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech Therapy Speech T		90% after deductible	70% after deductible	
Speech Therapy 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductibl		Therapy Services		
Speech Therapy 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductibl	Dhysical Madisina		70% after deductible	
Speech Therapy 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse 90% after deductible 70% after deductible 70% after deductible 10% after deductibl	Enysical Medicine	Limit: unlimited visit		
Cocupational Therapy 90% after deductible 70% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse Respiratory Therapy 90% after deductible 70% after d	Speech Therapy			
Occupational Therapy 90% after deductible 1imit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse Respiratory Therapy 90% after deductible 70% after deductible 70% after deductible 100% after deductible 70% after deductible 100% after deductible 70% after deductible 100% after deductible				
limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse Respiratory Therapy				
For the treatment of mental health or substance abuse	Occupational Therapy			
Respiratory Therapy 90% after deductible 70% after deductible Spinal Manipulations 90% after deductible 70% after deductible Limit: unlimited visits/benefit period Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) 90% after deductible 70% after deductible Mental Health / Substance Abuse				
Spinal Manipulations 90% after deductible Limit: unlimited visits/benefit period Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) 90% after deductible 70% after deductible 70% after deductible				
Spinal Manipulations Limit: unlimited visits/benefit period Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) 90% after deductible 70% after deductible Mental Health / Substance Abuse	Respiratory Therapy			
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) Mental Health / Substance Abuse	Spinal Manipulations			
Chemotherapy, Radiation Therapy and Dialysis) Mental Health / Substance Abuse	<u> </u>	Limit: unlimited visit	s/benefit period	
	Chemotherapy, Radiation Therapy and Dialysis)		70% after deductible	
Inpatient Mental Health Services 90% after deductible 70% after deductible				
	Inpatient Mental Health Services	90% after deductible	70% after deductible	

Benefit	In Network	Out of Network	
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible	
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible	
Outpatient Substance Abuse Services	90% after deductible	70% after deductible	
	Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible	
Autism Spectrum Disorder Applied Behavior Analysis (7)	90% after deductible	70% after deductible	
Assisted Fertilization Procedures	not covered	not covered	
Audiamatria Haaring Evam	90% after dedutible	70% after deductible	
Audiometric Hearing Exam	limit: 1 routine exar	n per 24 months	
Dental Services Related to Accidental Injury (10)	90% after deductible	70% after deductible	
Diabetes Treatment			
Equipment and Supplies	90% after deductible	70% after deductible	
Diabetes Education Program	90% after deductible	70% after deductible	
Diabetes Care Management Program (DCMP) - Digitally	100% (deductible does not apply)		
Monitored, includes telehealth consult for the A1C test	continuous glucose monitor sprints are	not covered	
	limited to three (3) per benefit period.		
DCMP - All Other Telehealth Consults	100% after deductible	not covered	
Piagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible	
	5570 aitoi doddolibiG	1070 and deductible	
Basic Diagnostic Services (standard imaging, diagnostic	90% after deductible	70% after deductible	
medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	
Mammograms, Medically Necessary	90% after deductible	70% after deductible	
Ourable Medical Equipment, Orthotics and Prosthetics			
Enteral Foods	90% after deductible	70% after deductible	
learing Aids	90% after deductible	70% after deductible	
	limit: \$1,000 pe		
Home Health Care	90% after deductible	70% after deductible	
	limit: 90 visits/benefit period a		
Home Infusion and Suite Infusion Therapy	90% after deductible	70% after deductible	
Hospice	90% after deductible	70% after deductible	
	limit: 180 days/b		
nfertility Counseling, Testing and Treatment (8) (10)	90% after deductible	70% after deductible	
Private Duty Nursing	90% after deductible	70% after deductible	
	limit: 240 hours/		
Skilled Nursing Facility Care	90% after deductible 70% after deductible		
	limit: 100 days/b		
Therapeutic Injections	90% after deductible	70% after deductible	
Fransplant Services (10)	90% after deductible	70% after deductible	
Precertification/Authorization Requirements (9)	Yes	Yes	
	Prescription Drugs		
Prescription Drug Deductible			
Individual	Integrated with medical deductible		
Family	Integrated with medical deductible		
Prescription Drug Program (11)	Retail Drugs (31/60/90-day Supply) Tier 1 Generic Drugs - Plan Pays 80% coinsurance with \$10 Minimum/ \$100 Maximum per Prescription after in-network deductible.		
Defined by the National Pharmacy Network - Not Physician			
Network. Prescriptions filled at a non-network pharmacy are not			
covered.	Tier 2 Generic Drugs - Plan Pays 80% coinsur	ance with \$10 minimum/\$100 maximum per	
/	prescription after in-n	etwork deductible.	
Your plan uses the Commercial Core Formulary with a Closed	Tier 3 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$10 Minimum/ \$100		
Benefit Design	Maximum per Prescription at	ter in-network deductible.	
Preventive Medications	Tier 4 Generic and Brand Drugs - Plan Pays	80% coinsurance with \$10 minimum/\$100	
Defined by Premier Pharmacy Network - Not Physician Network.	maximum per prescription after in-network deductible.		
Prescriptions filled at a non-network pharmacy are not covered	Maintenance Drugs through Mail Order (90-day Supply)		
Toomptione filled at a flort flotwork pliantacy are flot covered	Tier 1 Generic Drugs - Plan Pays 80% coinsurance with \$20 Minimum/ \$200 Maximum per		
	Prescription after in-network deductible.		
	Tier 2 Generic Drugs - Plan Pays 80% coinsurance with \$20 minimum/\$200 maximum per		
	prescription after in-network deductible.		
	Tier 3 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$20 Minimum/ \$200		
	Maximum per Prescription after in-network deductible.		
	Tier 4 Generic and Brand Drugs - Plan Pays	80% coinsurance with \$20 minimum/\$200	
	Tier 4 Generic and Brand Drugs - Plan Pays maximum per prescription at		
	maximum per prescription at	ter in-network deductible.	
	maximum per prescription at Preventive Prescription	ter in-network deductible. on Drugs – Premier	
	maximum per prescription at Preventive Prescriptio Retail Drugs (31/60	ter in-network deductible. on Drugs – Premier /90-Day Supply)	
	maximum per prescription at Preventive Prescriptio Retail Drugs (31/60 Tier 1 Generic Drugs - Plan Pays 80% coinsura	ter in-network deductible. on Drugs – Premier /90-Day Supply) ance with \$10 Minimum/ \$100 Maximum pe	
	maximum per prescription at Preventive Prescriptio Retail Drugs (31/60 Tier 1 Generic Drugs - Plan Pays 80% coinsura Prescription after in-n	ter in-network deductible. on Drugs – Premier //90-Day Supply) ance with \$10 Minimum/ \$100 Maximum per etwork deductible.	
	maximum per prescription at Preventive Prescriptio Retail Drugs (31/60 Tier 1 Generic Drugs - Plan Pays 80% coinsura Prescription after in-n Tier 2 Generic Drugs - Plan Pays 80% coinsur	ter in-network deductible. on Drugs – Premier //90-Day Supply) ance with \$10 Minimum/ \$100 Maximum per etwork deductible. ance with \$10 minimum/\$100 maximum per	
	maximum per prescription at Preventive Prescriptio Retail Drugs (31/60 Tier 1 Generic Drugs - Plan Pays 80% coinsura Prescription after in-n	ter in-network deductible. on Drugs – Premier //90-Day Supply) ance with \$10 Minimum/ \$100 Maximum per etwork deductible. ance with \$10 minimum/\$100 maximum per etwork deductible.	

Tier 3 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$10 Minimum/ \$100 Maximum per Prescription after in-network deductible.

Tier 4 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$10 minimum/\$100 maximum per prescription after in-network deductible.

Maintenance Drugs through Mail Order (90-day Supply)

Benefit	In Network	Out of Network
	Tier 1 Generic Drugs - Plan Pays 80% coinsurance with \$20 Minimum/ \$200 Maximum per	
	Prescription after in-network deductible.	
	Tier 2 Generic Drugs - Plan Pays 80% coinsurance with \$20 minimum/\$200 maximum per	
	prescription after in-network deductible.	
	Tier 3 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$20 Minimum/ \$200	
	Maximum per Prescription after in-network deductible.	
	Tier 4 Generic and Brand Drugs - Plan Pays 80% coinsurance with \$20 minimum/\$200	
	maximum per prescription after in-network deductible.	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include any medical and prescription drug deductibles, coinsurance, and copays. If you are enrolled in a "Family plan", with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. With your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. With your embedded TMOOP, once an individual's TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family TMOOP amount is satisfied collectively.
- (3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
- (6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
- (7) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g., speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
- (8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
- (10) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).
- (11) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary lists the specific drugs your program covers. To request a drug that is not on this formulary, your provider must complete the Prescription Drug Medication Request Form and return it to the Clinical Services Department for clinical review. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.