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.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual (non-embedded) Family	 $1,700 $3,400	 $3,400 $6,800
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes any medical and prescription drug coinsurance) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual (non-embedded) Family	 $2,000 $4,000	 $5,000 $10,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual (embedded) Family	 $5,000 $10,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	90% after deductible	70% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	90% after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	90% after deductible	70% after deductible
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Telemedicine Services (3)	$0 copay after deductible, 100% thereafter	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	70% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	70% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services (5)	90% after in-network deductible	
Ambulance - Emergency (6)	90% after deductible	90% after in-network deductible
Ambulance - non-emergency (6)	90% after deductible	70% after program deductible
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient (including maternity)	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Outpatient Surgery (facility)	90% after deductible	70% after deductible
Surgical Services (professional)	90% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter – ACT 81 no covered	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)	90% after deductible	70% after deductible
Therapy Services		
Physical Medicine	90% after deductible	70% after deductible
	Limit: unlimited visits/benefit period	
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	
Occupational 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 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		
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
Audiometric Hearing Exam	90% after dedutible	70% after deductible
	limit: 1 routine exam 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 Monitored, includes telehealth consult for the A1C test	100% (deductible does not apply) continuous glucose monitor sprints are limited to three (3) per benefit period.	not covered
DCMP - All Other Telehealth Consults	100% after deductible	not covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Mammograms, Medically Necessary	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Enteral Foods	90% after deductible	70% after deductible
Hearing Aids	90% after deductible	70% after deductible
	limit: $1,000 per 36 months	
Home Health Care	90% after deductible	70% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Home Infusion and Suite Infusion Therapy	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
	limit: 180 days/benefit period	
Infertility Counseling, Testing and Treatment (8) (10)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 100 days/benefit period	
Therapeutic Injections	90% after deductible	70% after deductible
Transplant Services (10)	90% after deductible	70% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (11) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Commercial Core Formulary with a Closed Benefit Design **Preventive Medications** Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered	**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. Tier 2 Generic Drugs - Plan Pays 80% coinsurance with $10 minimum/$100 maximum per prescription after in-network 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)** 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. **Preventive Prescription Drugs – Premier** **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. Tier 2 Generic Drugs - Plan Pays 80% coinsurance with $10 minimum/$100 maximum per prescription after in-network 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.