

Franklin & Marshall College – Groups 025339-66, 67, 68, 69, 70, 71

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	July 1, 2019	
Benefit Period (1)	Contract Year – July 1, 2019 through June 30, 2020	
Deductible (per benefit period)		
Individual	\$450	\$1,125
Family	\$900	\$2,250
Plan Pays – payment based on the plan allowance	95% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$1,000	\$5,000
Family	\$2,000	\$10,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$30 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$20 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$40 copay	70% after deductible
Virtual Visit Originating Site Fee	95% after deductible	70% after deductible
Urgent Care Center Visits	100% after \$30 copay	70% after deductible
Telemedicine Services (3)	100% after \$15 copay	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 Exam	100% (deductible does not apply)	70% (deductible does not apply)
Routine Pap Smear	100% (deductible does not apply)	70% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	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	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency	100% (deductible does not apply)	100% (deductible does not apply)
Ambulance - Non-Emergency	95% after deductible	70% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	\$100 inpatient copay/admission after deductible, 95% thereafter	\$750 inpatient copay/admission after deductible, 70% thereafter
Hospital Outpatient	95% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	\$100 inpatient copay/admission after deductible, 95% thereafter	\$750 inpatient copay/admission after deductible, 70% thereafter
Maternity for Dependent Daughters	95% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	95% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$20 copay	70% after deductible
Respiratory Therapy	100% after \$20 copay	70% after deductible
Speech Therapy	100% after \$20 copay	70% after deductible
Occupational Therapy	100% after \$20 copay	70% after deductible
Spinal Manipulations	100% after \$40 copay	70% after deductible
	limit: \$1,000/benefit period	

Benefit	In Network	Out of Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	95% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	\$100 inpatient copay/admission after deductible, 95% thereafter	\$750 inpatient copay/admission after deductible, 70% thereafter
Inpatient Detoxification / Rehabilitation	\$100 inpatient copay/admission after deductible, 95% thereafter	\$750 inpatient copay/admission after deductible, 70% thereafter
Outpatient Mental Health Services (includes virtual behavioral health visits)	95% after \$20 copay	70% after deductible
Outpatient Substance Abuse Services	100% after \$20 copay	70% after deductible
Other Services		
Allergy Extracts and Injections	95% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	95% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	95% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	95% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	95% after deductible	70% after deductible
Home Health Care	95% after deductible	70% after deductible
	limit: 60 visits/benefit period aggregate with visiting nurse	
Hospice	95% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (5)	95% after deductible individual 300 dollars/lifetime	70% after deductible individual 300 dollars/lifetime
	limit: \$2,400/lifetime	
Private Duty Nursing	95% after deductible	70% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	95% after deductible	70% after deductible
	limit: 50 days/benefit period	
Transplant Services	95% after deductible	not covered
Precertification Requirements (6)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (7) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Specialty Drugs are limited to 31-day Supply Specialty Drugs must be purchased at Retail or Mail Order.	<p style="text-align: center;">Retail Drugs (31-day Supply)</p> <p>15% for Generic drugs \$10 Minimum/ \$30 Maximum per Prescription 25% for Formulary brand drugs \$40 Minimum/ \$100 Maximum per Prescription 35% for Non-Formulary brand drugs \$100 Minimum/ \$160 Maximum per Prescription 35% for Specialty drugs \$100 Minimum/ \$160 Maximum per Prescription</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> <p>15% for Generic drugs \$24 Minimum/ \$74 Maximum per Prescription 25% for Formulary brand drugs \$80 Minimum/ \$200 Maximum per Prescription 35% for Non-Formulary brand drugs \$200 Minimum/ \$320 Maximum per Prescription 35% for Specialty drugs (31-day Supply) \$100 Minimum/ \$160 Maximum per Prescription</p>	
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	\$7,900 \$15,800	Not Applicable Not Applicable

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 which runs from July 1 to June 30.
- (2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
- (3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) 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.
- (6) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription 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. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHỦ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY: 711).

Geb Acht: Wann du Deutsch schwetzsch, kannst du en Dolmetscher griege, un iss die Hilf Koschdfrei. Kannst du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រាកដថា ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yánilti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jí' hodíilnih.

ध्यान दें: यदि आप हिनदी बोलते हैं, तो आपके लरि नऱिशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दरि गए नंबर पर फोन करें। (TTY: 711).

توجه فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడతే, లాగ్ వేక్ అసనఁతనన్ సర్వీసెన్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్సాయ్. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐఁడి) వెనుక ఉన్స నంబరుకు కాలి చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้ถูก โดยไม่มีค่าใช้จ่าย โทรไปแจ้ง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनुहोस्: यदतिपाई नेपाली भाषा बोलनुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू नऱिशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).