Summary of Benefits- MEBP Goshen College- 013127-00

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	7.1.2025	
Benefit Period (1)	Contract Year Begins July 1 and Ends June 30	
Deductible (per benefit period) (All services are credited to both in-network and out-of-network deductibles.) Individual Family	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) (All services are credited to both in-network and out-of-network out-of-pocket limits.) Individual Family	 $3,500 $7,000	 $6,500 $13,000
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	 $7,300 $14,600	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay; $25 copay for physician assistants; $25 copay for nurse practitioners	50% after deductible
Virtual Visit Provider Originating Site Fee	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $25 copay	50% after deductible
Telemedicine Services (3)	100% after $15 copayment (deductible does not apply)	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 not covered
Adult Immunizations	100% (deductible does not apply)	not covered
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	not covered
Mammograms, Annual Routine	100% (deductible does not apply)	not covered
Mammograms, Medically Necessary	70% after deductible	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 not covered
Pediatric Immunizations	100% (deductible does not apply)	not covered
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Emergency Services		
Emergency Room Services	If not admitted to hospital, you pay $250 copay – followed by deductible or coinsurance, if applicable	If not admitted to hospital, you pay $250 copay – followed by deductible or coinsurance, if applicable
Ambulance - Emergency and Non-Emergency	70% after deductible	70% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	70% after deductible	50% after deductible
Hospital Outpatient	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	70% after deductible	50% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay	50% after deductible
	limit: 25 visits/benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.	
Respiratory Therapy	70% after deductible	50% after deductible
Speech Therapy	100% after $25 copay	50% after deductible
	limit: 25 visits/benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.	
Occupational Therapy	100% after $25 copay	50% after deductible
	limit: 25 visits/benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.	
Spinal Manipulations	70% after deductible	50% after deductible
	limit: 25 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	70% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	70% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	70% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $25 copay	50% after deductible
Other Services		
Allergy Extracts and Injections	70% after deductible	50% after deductible
Assisted Fertilization Procedures	70% after deductible	50% after deductible
	limit: $5,000/lifetime	
Dental Services Related to Accidental Injury	70% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics **Foot Orthotics only covered if part of leg brace*	70% after deductible	50% after deductible
Home Health Care	70% after deductible	50% after deductible
Hospice	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (5)	70% after deductible	50% after deductible
Private Duty Nursing	70% after deductible	50% after deductible
Skilled Nursing Facility Care	70% after deductible	50% after deductible
	limit: 100 days/benefit period	
Transplant Services	100% for transportation, lodging and meal charges	50% after deductible
Transplant Travel, Lodging, Meals *$5,000 per transplant for the accompanying adult when pre-transplant evaluation, harvesting, stabilization and actual transplant is received by the recipient.*	100%, no deductible	not covered
Precertification Requirements (6)	Yes	Yes

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 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.

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）。

CHÚ 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 Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht 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).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

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

توجہ 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 మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको 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).