Summary of Benefits – Traditional Deductible Plan with PPO

Associated Mennonite Schools and Camps Benefits Plan

Medical benefits under this plan are provided through Highmark Blue Cross Blue Shield, a preferred provider organization (PPO). It is your responsibility to make sure that a medical care provider is a preferred provider before medical treatment is received. The medical care provider that you select can assist with this information.

Plan Requirements	In-Network	Out-of-Network
$250 deductible option:		
• Calendar-year deductible	• $250 per person; $500 per family.	• $500 per person; $1,000 per family.
• Calendar-year coinsurance	• You pay 50% of next $2,500 for all covered persons, combined.	• You pay 70% of next $2,500 for all covered persons, combined.
• Annual out-of-pocket maximum for deductible and coinsurance	• $1,500 per person; $1,750 per family.	• $2,250 per person; $2,750 per family.
• Total annual out-of-pocket maximum (deductible, coinsurance, office visit copays, Amwell copays, and prescription drug copays)	• $8,700 per person; $17,400 per family.	• $2,250 per person; $2,750 per family.
$500 deductible option:		
• Calendar-year deductible	• $500 per person; $1,000 per family.	• $1,000 per person; $2,000 per family.
• Calendar-year coinsurance	• You pay 50% of next $2,500 for all covered persons, combined.	• You pay 70% of next $2,500 for all covered persons, combined.
• Annual out-of-pocket maximum for deductible and coinsurance	• $1,750 per person; $2,250 per family.	• $2,750 per person; $3,750 per family.
• Total annual out-of-pocket maximum (deductible, coinsurance, office visit copays, Amwell copays, and prescription drug copays)	• $8,700 per person; $17,400 per family.	• $2,750 per person; $3,750 per family.
Precertification	You are responsible to contact Highmark Health Care Management Services 7-10 days prior to a planned inpatient admission or within 48 hours of an emergency admission.	
Filing claims	PPO provider files claims.	You are responsible to file claims.

Medical Benefits	In-Network	Out-of-Network[1]
Inpatient Facility Services		
• Hospital services[2]	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
• Skilled nursing facility care[2], up to 100 days per calendar year	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Outpatient Services		
• Physician office visit charge • Specialist office visit charge • Urgent care facility office visit charge	You pay $15 office visit copay.	You pay out-of-network deductible and coinsurance.
• Amwell virtual physician visits	You pay $10 copay.	No plan benefit outside of Amwell network of physicians.
• Physician/specialist/urgent care facility services other than office visit charge • Allergy testing and shots • Chemotherapy, radiation therapy, and kidney dialysis • Maternity care (physician fees) • Home health care • Health education programs • Medical supplies and equipment • Cardiac rehabilitation programs • Durable medical equipment and prosthetics • Outpatient surgery in hospital, outpatient surgical center, or physician office • X-ray, lab, and diagnostic services • Spinal manipulations, up to 20 visits per year • Physical therapy, up to 20 visits per year	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.

Medical Benefits	In-Network	Out-of-Network[1]
Outpatient Services (cont.)		
• Speech therapy, up to 20 visits per year • Occupational therapy, up to 20 visits per year	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Emergency Services		
• Ambulance • Hospital emergency room care	You pay in-network deductible and coinsurance.	
Adult Preventive Care Services[3]		
• Routine physical exams • Well-woman visits to obtain preventive services • Routine gynecological exam and pap test • Routine diagnostic screenings, including General Health Panel (GHP) • Routine annual prostate-specific antigen test • Mammograms – routine screening • As prescribed, FDA-approved contraceptive methods (including sterilization) for all women with reproductive capacity • Preventive care services, screenings and procedures for pregnant women • Breastfeeding (lactation) counseling and support, including costs of breastfeeding equipment • Services for prevention of obesity, heart disease, and diabetes • Routine adult immunizations	Plan pays 100%.	No plan benefit.
Pediatric Preventive Care Services[3]		
• Routine physical exams • Routine pediatric immunizations • Routine diagnostic screening • Services for prevention of obesity and heart disease	Plan pays 100%.	No plan benefit.
Hospice Services		
• Inpatient services[2] • Outpatient services	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Mental Health Services		
• Inpatient treatment[2] • Outpatient treatment	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Substance Abuse Services		
• Inpatient detoxification[2] • Inpatient rehabilitation[2] • Outpatient treatment	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.

[1]Plan payments for services received from an out-of-network provider are based on the allowable charge for the type of care, service, or treatment received. If the provider's charges are more than the allowable charge, you will be responsible for paying the difference. Any of these extra amounts you have to pay will not count toward your calendar-year deductible and coinsurance requirements or the total annual out-of-pocket maximum.

[2]Precertification required. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

[3]The complete schedule of covered preventive services is outlined in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule* which are updated periodically based on changes in clinical practice guidelines.

Outpatient Prescription Drug Benefit[4]	
• Tier 1 Generic drugs	You pay 10% copay[5]
• Tier 2 Preferred brand-name drugs on the Preferred Drug List	You pay 20% copay[5]
• Tier 3 All other brand-name drugs	You pay 50% copay[5]
• Tier 4 Specialty pharmaceuticals[6]	You pay 30% copay[5]; annual out-of-pocket maximum for copays for specialty pharmaceuticals is $3,000 per covered person.

[4]Outpatient prescription drugs are provided through the Express Scripts pharmacy network. Mandatory step therapy applies.

[5]Copays for outpatient prescription drugs are not counted toward meeting your calendar-year deductible and coinsurance requirements.

[6]Prior authorization required for all specialty pharmaceuticals.