Summary of Benefits

Mennonite Educators Benefit Plan – Anabaptist Mennonite Biblical Seminary, Goshen College, Mennonite Education Agency, Inc.

Medical benefits under this plan are provided through the Highmark Blue Cross Blue Shield Preferred Provider Organization (PPO) Program. It is your responsibility to make sure that a health care provider is a network provider before medical treatment is received. The health care provider that you select can assist with this information.

Plan Requirements	In-Network	Out-of-Network
Plan-year deductible	$1,500 individual; $3,000 per family.	$3,000 individual; $6,000 per family.
Plan-year coinsurance	You pay 30% of next $5,000 individual; 30% of next $10,000 per family.	You pay 50% of next $5,000 individual; 50% of next $10,000 per family.
Annual out-of-pocket maximum for deductible and coinsurance	$3,000 individual; $6,000 per family.	$5,500 individual; $11,000 per family.
Total annual out-of-pocket maximum (deductible; coinsurance; office/virtual visit, ER, and RX drug copays except for specialty SaveOn drugs)	$7,300 individual; $14,600 per family.	$5,500 individual; $11,000 per family.
Lifetime maximum benefit for assisted fertilization services	$5,000 for each covered person.	
Pre-certification[2]: Pre-certification may be required by Highmark to determine the medical necessity and appropriateness of certain outpatient procedures and ALL inpatient stays prior to the receipt of services. Information should be forwarded to Highmark 7-10 days prior to a planned procedure or inpatient admission and within 48 hours of an emergency.		
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] • Skilled nursing facility care[2], up to 100 days per plan year	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.
Outpatient Services		
• Physician/specialist office visit charge • Urgent care facility office visit charge • Physical medicine, up to 25 visits per year • Speech therapy, up to 25 visits per year • Occupational therapy, up to 25 visits per year	You pay $25 office visit copay.	You pay out-of-network deductible and coinsurance.
• Well360 Virtual Health visits	You pay $15 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, orthotics and prosthetics • Outpatient surgery in hospital, outpatient surgical center, or physician office • X-ray, lab, and diagnostic services • Spinal manipulations, up to 25 visits per year • Assisted fertilization services, up to the lifetime maximum *(The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse)*	You pay in-network deductible and coinsurance.	You pay out-of-network deductible and coinsurance.

Emergency Services	
• Ambulance	You pay in-network deductible and coinsurance.
Hospital emergency room care: Facility charges	• If admitted to hospital, you pay in-network deductible and coinsurance. • If not admitted to hospital, you pay $250 copay – no deductible or coinsurance.
• Other services billed separately by emergency room providers	You pay in-network deductible and coinsurance.

Medical Benefits	**In-Network**	**Out-of-Network[1]**
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 a complete blood count (CBC), urinalysis, and general health panel (GHP) • Annual routine prostatic specific antigen test and/or digital rectal exam • Mammograms – annual 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.
• Immunizations required for foreign travel	Plan pays 100%.	
Pediatric Preventive Care Services[3]		
• Routine physical exams • Routine pediatric immunizations • Routine diagnostic screenings • Services for prevention of obesity and heart disease	Plan pays 100%.	No plan benefit.
• Immunizations required for foreign travel	Plan pays 100%.	
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	Paid the same as any other service according to type of service, provider and place of service.	You pay out-of-network deductible and coinsurance.
Substance Abuse Services		
• Inpatient detoxification[2] • Inpatient rehabilitation[2] • Outpatient treatment	Paid the same as any other service according to type of service, provider and place of service.	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 plan-year deductible and coinsurance requirements or the total annual out-of-pocket maximum.

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

[3]The schedule of covered preventive services including preventive drug measures 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 30% copay[5]
• Tier 3 All other brand-name drugs	You pay 50% copay[5]
• Tier 4 Specialty pharmaceuticals[6]	You pay 30% copay[5]
Specialty drugs obtained through SaveOn SP Precision program	You pay 30% copay

[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 plan-year deductible and coinsurance requirements.

[6]Prior authorization required for all specialty pharmaceuticals.