Summary of Benefits – MHS Medical Expense Plan for Oaklawn

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
Calendar-year deductible	$1,000 per person; $1,500 per family.	$2,000 per person; $3,000 per family.
Calendar-year coinsurance*	You pay 20% of next $5,000 per person or 20% of $10,000 per family*.	You pay 40% of all remaining charges for the rest of the calendar year.
Annual out-of-pocket maximum for deductible and coinsurance only	$2,000 per person; $3,500 per family.	No annual out-of-pocket maximum.
Total annual out-of-pocket maximum (deductible; coinsurance; office visit, emergency room and prescription drug copays)	$7,150 per person; $14,300 per family.	No total annual out-of-pocket maximum.
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.

**The coinsurance requirement is waived for allowed charges when designated conditions are treated in and billed by a Blue Distinction Center or Blue Distinction Center+ facility.*

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 $25 office visit copay.	You pay out-of-network deductible and coinsurance.
• 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 • Annual eye examination • Spinal manipulations, up to 20 visits per year • Physical medicine, up to 20 visits per year • 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	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 $100 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 screening • Mammograms – annual routine • As prescribed, FDA-approved contraceptive methods (including sterilization) for all women with reproductive capacity • Lactation counseling and support, including rental of breastfeeding equipment • Immunizations	Plan pays 100%.	No plan benefit.
Pediatric Preventive Care Services[3]		
• Routine physical exams • Pediatric immunizations • Routine diagnostic screening	Plan pays 100%.	No plan benefit.
Health and Wellness Resources		
• 24/7 health coach consultation • On-line health improvement programs • On-line health risk assessment	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	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[6].
• Tier 2 Preferred brand-name drugs on the Preferred Drug List[5]	You pay 30% copay[6].
• Tier 3 All other brand-name drugs[5]	You pay 50% copay[6].
• Tier 4 Specialty pharmaceuticals[5]	You pay 30% copay[6].

Targeted Therapeutic Class Tiers for cholesterol, diabetes, and cardiovascular drugs[4]	
• Tier 1 Generic drugs and diabetic supplies	You pay 10% copay ($2 maximum)[6] for retail (34-day or 100-unit supply) or mail order purchase (90-day supply).
• Tier 2 Preferred brand-name drugs on the Preferred Drug List[5]	You pay $20 copay[6] for retail purchase (34-day or 100-unit supply); $40 copay[6] for mail order purchase (90-day supply). You pay cost of the drug if less than the copay.
• Tier 3 All other brand-name drugs[5]	You pay $35 copay[6] for retail purchase (34-day or 100-unit supply); $70 copay[6] for mail order purchase (90-day supply). You pay cost of the drug if less than the copay.

[4]Prior authorization required for compound drugs costing $300 or more, any drug costing $5,000 or more, and all specialty pharmaceuticals.

[5]Mandatory generic step therapy applies.

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