Milton Hershey School Benefit Comparison 2017

Benefit	PPO Basic		PPO Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible *Per Contract Year*	None	$2,000 Individual $4,000 Family	None	$250 Individual $500 Family
Plan Pays – *payment based on the plan allowance*	100%	60% after deductible until OOP max is met, then 100%	100%	80% after deductible until OOP max is met, then 100%
Out-of-Pocket Limit *Includes Coinsurance-See benefit booklet for exclusions/details*	None	$5,000 Individual $15,000 Family Aggregate	None	$1,500 Individual $3,000 Family Aggregate
Total Maximum Out of Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only). Once met, the plan pays 100% of covered services for the rest of the benefit period.				
Individual Family	$7,150 $14,300	Not Applicable Not Applicable	$7,150 $14,300	Not Applicable Not Applicable
Ambulance	100%	60% after deductible	100%	80% after deductible
Assisted Fertilization	Not Covered	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered	Not Covered	Not Covered
Diabetes Treatment	100%	60% after deductible	100%	80% after deductible
Diagnostic Services *(Lab, X-ray, and Medical Tests)*	100%	60% after deductible	100%	80% after deductible
DME, Orthotics, Prosthetics	100%	60% after deductible	100%	80% after deductible
Elective Abortion *Includes Dependent Daughters*	100%	60% after deductible	100%	80% after deductible
Emergency Care *Professional Services*	100%	100% no deductible	100%	100% no deductible
Emergency Room	100% after $75 copayment (waived if admitted)		100% after $35 copayment (waived if admitted)	
Enteral Formulae	100%	60% no deductible	100%	80% no deductible
Hearing Care Services	Not Covered	Not Covered	100%	50% after deductible
			$1,500 total max for both ears per 36 month period which includes device exam, fitting, repairs, and replacements; 1 audiometric exam/diagnostic testing per year	

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Benefit	PPO Basic		PPO Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Home Health Care *Excludes Respite Care*	100%	60% after deductible	100%	80% after deductible
	90 visits/calendar year		90 visits/calendar year	
Hospice *Includes Respite Care*	100%	60% after deductible	100%	80% after deductible
Hospital Expenses *IP and OP*	100%	60% after deductible	100%	80% after deductible
	365 days 2 pint blood deductible/calendar year		365 days 2 pint blood deductible/calendar year	
Infertility Counseling, Testing & Treatment	100%	60% after deductible	100%	80% after deductible
Maternity *Includes Dependent daughter*	100%	60% after deductible	100%	80% after deductible
Medical Care *Includes Inpatient Visits and Consultations*	100%	60% after deductible	100%	80% after deductible
Mental Health – IP	100%	60% after deductible	100%	80% after deductible
Mental Health – OP	100%	60% after deductible	100%	80% after deductible
Office Visits (Primary Care and Specialist)	100% after $20 copayment	60% after deductible	100% after $5 copayment	80% after deductible
Retail Clinic Visit & Virtual Visits	100% after $20 copayment	60% after deductible	100% after $5 copayment	80% after deductible
Virtual Visit Originating Site Fee	100%	60% after deductible	100%	80% after deductible
Urgent Care Center Visits	100% after $20 copayment	60% after deductible	100% after $5 copayment	80% after deductible
Telemedicine Services	100% after $20 copayment	Not covered	100% after $5 copayment	Not covered
Physical Medicine – *Outpatient*	100%	60% after deductible	100%	80% after deductible
	20 visits/calendar year		30 visits/calendar year	
Oral Surgery	100%	60% after deductible	100%	80% after deductible
Preventive Care *Routine Adult Services Include:*				
Physical Exam	100%	60% after deductible	100%	80% after deductible
Gynecological Exam & Pap Test	100%	60% no deductible/ maximum	100%	80% no deductible/ maximum
Mammograms	100%	60% after deductible	100%	80% after deductible
Preventive Care 2017	100%	60% after deductible	100%	80% after deductible

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Benefit	PPO Basic		PPO Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Pediatric *Services Include:*				
Physical Exams	100%	60% after deductible	100%	80% after deductible
Pediatric Immunizations	100%	60% no deductible/maximum	100%	80% no deductible/ maximum
Preventive Care 2017	100%	60% after deductible	100%	80% after deductible
Private Duty Nursing	100%	60% after deductible	100%	80% after deductible
	240 hours/calendar year		240 hours/calendar year	
Skilled Nursing Facility Care	100%	60% after deductible	100%	80% after deductible
	100 days/calendar year		100 days/calendar year	
Speech & Occupational Medicine Outpatient	100%	60% after deductible	100%	80% after deductible
	12 visits/calendar year per type of therapy		12 visits/calendar year per type of therapy	
Spinal Manipulations	100%	60% after deductible	100%	80% after deductible
	20 visits/calendar year		30 visits/calendar year	
Substance Abuse - Detox	100%	60% after deductible	100%	80% after deductible
Substance Abuse – IP Rehab	100%	60% after deductible	100%	80% after deductible
Substance Abuse – OP	100%	60% after deductible	100%	80% after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia. Sterilization , Reversal Procedures and Neonatal Circumcisions*	100%	60% after deductible	100%	80% after deductible
Therapy Services *Chemotherapy, Radiation Therapy, Infusion Therapy, Respiratory Therapy & Dialysis*	100%	60% after deductible	100%	80% after deductible
Precertification Requirements for IP Admissions *No Penalty for Non-compliance*	Performed by Network Provider	Performed by Member	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call and Disease State Management		Case Management, Blues on Call and Disease State Management	

Milton Hershey School Benefit Comparison 2017

Prescription Drug Program Benefits – National Pharmacy Network	PPOBlue Basic		PPOBlue Enhanced	
	Retail	**Mail Order**	**Retail**	**Mail Order**
Deductible	None	None	None	None
Generic Prescription Drug	$10 copayment	$10 copayment	$5 copayment	$0 copayment
Brand Prescription Drug	Not Applicable	Not Applicable	$10 copayment	$20 copayment
Brand Formulary Prescription Drug	$30 copayment View the comprehensive formulary at www.highmarkblueshield.com	$40 copayment View the formulary at www.highmarkblueshield.com	Not Applicable	Not Applicable
Brand Non-Formulary Prescription Drug	$45 copayment View the comprehensive formulary at www.highmarkblueshield.com	$80 copayment View the formulary at www.highmarkblueshield.com	Not Applicable	Not Applicable
Days Supply *(per prescription)*	Up to 30 day supply (with 1 refill – mandatory mail provision)	Up to 90 day supply	Up to 30 day supply (with 1 refill – mandatory mail provision)	Up to 90 day supply
Generic Substitution *(Soft)*	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, unless your physician requests that the brand name drug be dispensed.		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, unless your physician requests that the brand name drug be dispensed.	
Out of Pocket Maximum	Not Applicable	$1,000 per person	Not Applicable	$250 Individual $500 Family
Claim Submission	Pharmacy Files at Point-of-Sale		Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Not Covered		Not Covered	
Contraceptives *(oral and injectable)*	Covered		Covered	
Quantity Level Limits *on select prescription drugs*	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines		Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines	
Managed Rx Coverage *on certain drug therapies*	Not Applicable		Not Applicable	
Managed Prior Authorizations	Applies on select high cost drugs		Applies on select high cost drugs	

Additional Information about the Milton Hershey School Benefit Plans:

- PPO Medical Plans are not "grandfathered plans" anymore. A few of the changes to the plans include the following.
  - Total Maximum Out-of-Pocket In-Network– is $7,150 for Single coverage and $14,300 for Family coverage
  - Preventive Services – covered at 100% in-network
  - Pharmacy Network – renamed to National Network, includes Target. Walgreen's is still excluded.
  - Hospice Max – maximum number of days covered has been removed
  - Clinical Trials – coverage approve for approved clinical trials
- For details, please contact your participating provider or Highmark directly at 1-866-228-9468.