| HOW MUCH YOU WILL PAY IN 2020 | HOP MEDICAL PLAN |
|---|---|
| **MEDICAL PLAN** | |
| Annual Deductible | $0 |
| Annual Out-of-Pocket Maximum | Only applies to Major Medical benefits (see below) |
| Hospitalization | $0 |
| Doctor Visits | $10 PCP; $20 specialist |
| Preventive Care | $0 (Medicare-covered services) |
| Emergency Room | $40 (waived if admitted) |
| Urgent Care Facility | $15 |
| Outpatient Surgery | $0 |
| Diagnostic Testing | $0 (X-ray and laboratory); $25 (imaging, e.g., MRI and CT scans) |
| Outpatient Therapy | $0 |
| Durable Medical Equipment | 10% up to $100/item |
| Outpatient Mental Health | $10/visit (office visit) or $0 (other services) |
| Inpatient Mental Health | $0 |
| Physical Exams | Not covered (unless approved by Medicare) |
| Ob/Gyn Exams | $10/exam |
| Mammograms | $0 |
| Skilled Nursing Facility | $0/day for 1 to 100 days (Major Medical benefits for days 101+) |
| Hearing Aids | Not covered |
| Dental Care | Not covered |
| Vision Exam/Hearing Exams | Not covered |
| Prescription Lenses | Not covered |
| Major Medical (after Medicare benefits are exhausted) | |
| All covered expenses | $250 deductible, then 20% |
| Annual Out-of-Pocket Maximum | $1,000 |
| Lifetime maximum paid by the Plan for Major Medical benefits | $1,000,000 |

See the *HOP Medical Plan Summary Plan Description* for a complete list of covered services, exclusions and limitations, as applicable.

| | ENHANCED MEDICARE Rx OPTION | | BASIC MEDICARE Rx OPTION | |
|---|---|---|---|---|
| **PRESCRIPTION DRUGS** | **Retail Pharmacy** | **Mail Order** | **Retail Pharmacy** | **Mail Order** |
| Annual Deductible | $0 | $0 | $100 (excludes generics) | |
| Initial Coverage Up to a Total Drug Cost of $4,020* | | | | |
| Preferred generic drugs (Tier 1) | $4 maximum for up to a 30-day supply; $12 for a 31- to 90-day supply | $12 for a 31- to 90-day supply | $5 maximum for up to a 30-day supply; $15 for a 31- to 90-day supply | $15 for a 31- to 90-day supply |
| Non-preferred generic drugs (Tier 2) | $11 maximum for up to a 30-day supply; $33 for a 31- to 90-day supply | $33 for a 31- to 90-day supply | $12 maximum for up to a 30-day supply; $36 for a 31- to 90-day supply | $36 for a 31- to 90-day supply |
| Preferred brand-name drugs (Tier 3) | 25% to a maximum of $150 for up to a 30-day supply and $300 for a 31- to 90-day supply | 25% to a maximum of $280 for a 31- to 90-day supply | 30% to a maximum of $200 for up to a 30-day supply and $500 for a 31- to 90-day supply | 30% to a maximum of $450 for a 31- to 90-day supply |
| Non-preferred drugs (Tier 4) | 35% to a maximum of $200 for up to a 30-day supply and $400 for a 31- to 90-day supply | 35% to a maximum of $380 for a 31- to 90-day supply | 40% | 40% |
| Specialty drugs (Tier 5; limited to a 30-day supply) | 33% | 33% | 30% | 30% |
| Coverage Gap to TrOOP Maximum of $6,350** | | | | |
| Generic drugs*** | 25% | 25% | 25% | 25% |
| Brand-name drugs*** | 25% (plan pays 5% and manufacturer discounts 70%) | | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Catastrophic Coverage | | | | |
| Generic drugs*** | The greater of 5% or $3.60 to a maximum of $100 | | The greater of 5% or $3.60 to a maximum of $250 | |
| Brand-name drugs*** | The greater of 5% or $8.95 to a maximum of $100 | | The greater of 5% or $8.95 to a maximum of $250 | |

* Includes total combined costs for covered drugs paid by the plan and participant

** True Out of Pocket (TrOOP) includes costs for covered drugs paid by the participant (but not the plan) and manufacturer's discount

*** Including specialty drugs

| HOW MUCH YOU WILL PAY IN 2020 | VALUE MEDICAL PLAN |
|---|---|
| **MEDICAL PLAN** | |
| Annual Deductible | $185 (in 2019) |
| Annual Out-of-Pocket Maximum | $5,000 |
| Hospitalization | $300/admission |
| Doctor Visits | 20% to a maximum of $20/visit |
| Preventive Care | $0 (Medicare-covered services) |
| Emergency Room | $50 (waived if admitted) |
| Urgent Care Facility | 20% to a maximum of $20/visit |
| Outpatient Surgery | 20% to a maximum of $100/procedure |
| Diagnostic Testing | 20% (to a maximum of $100/procedure for MRIs and CT scans) |
| Outpatient Therapy | 20% |
| Durable Medical Equipment | 20% |
| Outpatient Mental Health | 20% to a maximum of $20/visit |
| Inpatient Mental Health | $300/admission |
| Physical Exams | Not covered (unless approved by Medicare) |
| Ob/Gyn Exams | 20% to a maximum of $20/visit |
| Mammograms | $0 |
| Skilled Nursing Facility | $0/day for 1-20 days; $50/day for 21 – 100 days; not covered days 101+ |
| Hearing Aids | Not covered |
| Dental Care | Not covered |
| Vision Exam/Hearing Exams | Not covered |
| Prescription Lenses | Not covered |
| Major Medical (after Medicare benefits are exhausted) | Not covered |

See the *Value Medical Plan Summary Plan Description* for a complete list of covered services, exclusions and limitations, as applicable.

| | VALUE MEDICARE Rx OPTION | |
|---|---|---|
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $435 (excludes preferred generic drugs) | |
| **Initial Coverage Up to a Total Drug Cost of $4,020*** | | |
| Preferred generic drugs (Tier 1) | $2 for a 30-day supply; $6 for a 31- to 90-day supply | |
| Generic drugs (Tier 2) | 25% | 25% |
| Preferred brand-name drugs (Tier 3) | 25% | 25% |
| Non-preferred drugs (Tier 4) | 25% | 25% |
| Specialty drugs (Tier 5; limited to a 30-day supply) | 25% | 25% |
| **Coverage Gap to TrOOP Maximum of $6,350**** | | |
| Generic drugs*** | 25% | 25% |
| Brand-name drugs*** | 25% (plan pays 5% and manufacturer discounts 70%) | |
| **Catastrophic Coverage** | | |
| Generic drugs*** | The greater of 5% or $3.60 | |
| Brand-name drugs*** | The greater of 5% or $8.95 | |

* Includes total combined costs for covered drugs paid by the plan and participant

** True Out of Pocket (TrOOP) includes costs for covered drugs paid by the participant (but not the plan) and manufacturer's discount

*** Including specialty drugs

| HOW MUCH YOU WILL PAY IN 2020 | HIGHMARK FREEDOM BLUE PPO | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $0 | $0 |
| Annual Out-of-Pocket Maximum | $3,400 (combined) | |
| Hospitalization | $0 | $0 |
| Doctor Visits | $10 PCP; $15 specialist | $10 PCP; $15 specialist |
| Preventive Care | $0 | $0 |
| Emergency Room | $50 (waived if admitted) | $50 (waived if admitted) |
| Urgent Care Facility | $40 | $40 |
| Outpatient Surgery | $0 | $0 |
| Diagnostic Testing | $0 | $0 |
| Outpatient Therapy | $15 | $15 |
| Durable Medical Equipment | 15% | 20% |
| Outpatient Mental Health | $15 | $15 |
| Inpatient Mental Health | $0 | $0 |
| Physical Exams | $0 (office visit copay may apply) | $0 (office visit copay may apply) |
| Ob/Gyn Exams | $0 (office visit copay may apply) | $0 (office visit copay may apply) |
| Mammograms | $0 | $0 |
| Skilled Nursing Facility | $0 up to 100 days per Medicare Benefit Period | $0 up to 100 days per Medicare Benefit Period |
| Hearing Aids | $0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium; $500 allowance per year for other aids through TruHearing | 100% after a $500 allowance for hearing aids every three years from any other provider or TruHearing |
| Dental Care (subject to frequency limitations) | $20 for exam & cleaning and $20 for X-rays every 6 months; 50% for restorative services and dentures | 50% for periodic exams, cleanings, X-rays, fillings as needed and dentures |
| Vision Exam/Hearing Exams | $0 vision; $15 hearing | $50 vision; 20% hearing |
| Prescription Lenses | 100% after a $100 benefit maximum per calendar year for standard eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full (annually) | 100% after a $100 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses, or contact lenses |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (31-day supply)** | **Mail Order (90-day supply)*** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Non-preferred generic drugs (Tier 2) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Preferred brand-name drugs (Tier 3) | $25 preferred pharmacy; $30 standard pharmacy | $62.50 |
| Non-preferred brand-name drugs (Tier 4) | $55 preferred pharmacy; $60 standard pharmacy | $137.50 |
| Specialty drugs (Tier 5) | 33% | Not covered |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Brand-name drugs (Tiers 3 & 4) | Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%) | 20% (plan pays 10% and manufacturer discounts 70%) |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | Not covered |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Must obtain mail order supply using Express Scripts/ESI.

| HOW MUCH YOU WILL PAY IN 2020 | AETNA MEDICARE V02 PPO* | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $300 | $500 |
| Annual Out-of-Pocket Maximum | $6,700 | $10,000 |
| Hospitalization | $200 copay/day for days 1–7 | 30% |
| Doctor Visits | $15 PCP; $40 specialist | 30% |
| Preventive Care | $0 | 30% |
| Emergency Room | $90 (waived if admitted) | $90 (waived if admitted) |
| Urgent Care Facility | $50 | $50 |
| Outpatient Surgery | $185 | 30% |
| Diagnostic Testing | $35; $200 complex imaging | 30% |
| Outpatient Therapy | $40 | 30% |
| Durable Medical Equipment | 20% | 30% |
| Outpatient Mental Health | $40 | 30% |
| Inpatient Mental Health | $200 copay/day for days 1–7 | 30% |
| Physical Exams | $0 | 30% |
| Ob/Gyn Exams | $0 | 30% |
| Mammograms | $0 | 30% |
| Skilled Nursing Facility | $0 days 1-20; $172 days 21-100 | 30% |
| Hearing Aids (once every 36 months) | 100% after $500 allowance | |
| Dental Care (subject to frequency limitations) | Not covered | Not covered |
| Vision Exam/Hearing Exams | $0 | 30% |
| Prescription Lenses | 100% after $100 allowance (once every 24 months) | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $2 preferred pharmacy; $15 standard pharmacy | $4 preferred pharmacy; $30 standard pharmacy |
| Non-preferred generic drugs (Tier 2) | $10 preferred pharmacy; $20 standard pharmacy | $20 preferred pharmacy; $40 standard pharmacy |
| Preferred brand-name drugs (Tier 3) | $40 preferred pharmacy; $47 standard | $80 preferred pharmacy; $94 standard |
| Non-preferred brand-name drugs (Tier 4) | 35% preferred pharmacy; 50% standard | |
| Specialty drugs (Tier 5) | 33% | 33% (limited one-month supply) |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Preferred generic drugs (Tier 1) | $2 preferred pharmacy; $15 standard pharmacy | $4 preferred pharmacy; $30 standard pharmacy |
| Non-preferred generic drugs (Tier 2) | $10 preferred pharmacy; $20 standard pharmacy | $20 preferred pharmacy; $40 standard pharmacy |
| Brand-name drugs (Tiers 3 & 4) | 25% | 25% |
| Specialty drugs (Tier 5) | 25% | 25% |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Aetna is available only in Pennsylvania, New Jersey and some counties in Florida, Maryland, and New York.

| HOW MUCH YOU WILL PAY IN 2020 | UPMC *FOR LIFE* HMO* | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | |
| Annual Deductible | $0 | |
| Annual Out-of-Pocket Maximum | $3,400 | |
| Hospitalization | $0 inpatient; $0 outpatient | |
| Doctor Visits | $5 PCP; $20 specialist | |
| Preventive Care | $0 | |
| Emergency Room | $120 (waived if admitted within 3 days) | |
| Urgent Care Facility | $20 | |
| Outpatient Surgery | $0 | |
| Diagnostic Testing | $0 labs; $10 X-rays; $30 advanced imaging | |
| Outpatient Therapy | $20 | |
| Durable Medical Equipment | 15% | |
| Outpatient Mental Health | $20 | |
| Inpatient Mental Health | $0 | |
| Physical Exams | $0 routine | |
| Ob/Gyn Exams | $0 routine | |
| Mammograms | $0 routine | |
| Skilled Nursing Facility | $0 per day days 1-15; $50 per day days 16-100 | |
| Hearing Aids | 100% after $1,500 allowance (once every 36 months) | |
| Dental Care | Routine dental not covered | |
| Vision Exam/Hearing Exams | $0 routine vision (once every two years); $20 routine hearing (once every year) | |
| Prescription Lenses (once every 24 months) | 100% after $250 allowance | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $0 preferred pharmacy; $15 standard pharmacy | $0 standard |
| Non-preferred generic drugs (Tier 2) | $10 preferred pharmacy; $20 standard pharmacy | $20 standard |
| Preferred brand-name drugs (Tier 3) | $47 preferred or standard pharmacy | $105 standard |
| Non-preferred brand-name drugs (Tier 4) | $100 preferred or standard pharmacy | $285 standard |
| Specialty drugs (Tier 5) | 33% | Not covered |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Preferred generic drugs (Tier 1) | $0 preferred pharmacy; $15 standard pharmacy | $0 standard |
| Non-preferred generic drugs (Tier 2) | $10 preferred pharmacy; $20 standard pharmacy | $20 standard |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | Not covered |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* UPMC is available in all South East, South West Pennsylvania counties and some North Central Pennsylvania counties.

| HOW MUCH YOU WILL PAY IN 2020 | INDEPENDENCE BLUE CROSS KEYSTONE 65 SELECT HMO ($5/$40) | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | |
| Annual Deductible | $0 | |
| Annual Out-of-Pocket Maximum | $6,700 | |
| Hospitalization | $150 copay, days 1–6; $900 copay max/stay | |
| Doctor Visits | $5 PCP; $40 specialist | |
| Preventive Care | $0 | |
| Emergency Room | $90 (waived if admitted) | |
| Urgent Care Facility | $5 retail clinic; $40 urgent care | |
| Outpatient Surgery | $200 hospital; $100 ASC | |
| Diagnostic Testing | $0 labs; $25 X-rays; $200 advanced imaging | |
| Outpatient Therapy | $20 ($5 pulmonary/cardiac rehab) | |
| Durable Medical Equipment | $0 diabetic supplies; 20% DME, prosthetics, orthotics | |
| Outpatient Mental Health | $40 | |
| Inpatient Mental Health | $150 copay, days 1–6; $900 copay max/stay; 190-day lifetime max for Medicare-approved facility | |
| Physical Exams | $0 | |
| Ob/Gyn Exams | $0 (routine every two years) | |
| Mammograms | $0 | |
| Skilled Nursing Facility | $0 days 1-20; $165 days 21-100 | |
| Hearing Aids | Not covered | |
| Dental Care | Not covered | |
| Vision Exam/Hearing Exams | $40 for Medicare-covered, routine exams | |
| Prescription Lenses (once every 24 months) | $0 for standard lenses and frames or contacts; 100% after $100 allowance for nonstandard frames and specialty contacts | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy | $24 preferred pharmacy |
| Preferred brand-name drugs (Tier 3) | $30 | $60 preferred pharmacy |
| Non-preferred brand-name drugs (Tier 4) | $50* | $100 preferred pharmacy |
| Specialty drugs (Tier 5) | 33% | 33% |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy. | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy* | $24 preferred pharmacy |
| Brand-name drugs (Tiers 3 & 4) | Preferred and non-preferred drugs: 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* May also include non-preferred generic drugs.

| HOW MUCH YOU WILL PAY IN 2020 | AETNA MEDICARE P02 HMO | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | |
| Annual Deductible | $0 | |
| Annual Out-of-Pocket Maximum | $6,700 | |
| Hospitalization | $0 inpatient; $0 outpatient | |
| Doctor Visits | $10 PCP; $15 specialist | |
| Preventive Care | $0 | |
| Emergency Room | $50 (waived if admitted) | |
| Urgent Care Facility | $35 | |
| Outpatient Surgery | $0 | |
| Diagnostic Testing | $15 | |
| Outpatient Therapy | $15 | |
| Durable Medical Equipment | $0 | |
| Outpatient Mental Health | $15 | |
| Inpatient Mental Health | $0 | |
| Physical Exams | $0 | |
| Ob/Gyn Exams | $0 | |
| Mammograms | $0 | |
| Skilled Nursing Facility | $0 limited to 100 days | |
| Hearing Aids | $500 allowance (once every 36 months) | |
| Dental Care | $5 (preventive); non-routine care covered by Medicare | |
| Vision Exam/Hearing Exams | $0 (once every 12 months) | |
| Prescription Lenses | $100 allowance (once every 24 months) | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 | $10 |
| Non-preferred generic drugs (Tier 2) | $5 | $10 |
| Preferred brand-name drugs (Tier 3) | $25* | $50* |
| Non-preferred brand-name drugs (Tier 4) | $50* | $100* |
| Specialty drugs (Tier 5) | 33% | 33% |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | $5 | $10 |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Copay also applies to some high-cost generics.

| HOW MUCH YOU WILL PAY IN 2020 | INDEPENDENCE BLUE CROSS–PERSONAL CHOICE 65 PPO | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $0 | $500 |
| Annual Out-of-Pocket Maximum | $6,700 | $10,000 (in- and out-of-network combined) |
| Hospitalization | $100/stay (days 1–10) | 30% after deductible |
| Doctor Visits | $20 PCP; $35 specialist | 30% after deductible |
| Preventive Care | $0 | 30% |
| Emergency Room | $40 not waived if admitted | $40 |
| Urgent Care Facility | $35 | $35 |
| Outpatient Surgery | $150 | 30% after deductible |
| Diagnostic Testing | $0 lab and diagnostic tests; $35 X-rays and diagnostic radiology | 30% after deductible |
| Outpatient Therapy | $35; $5 pulmonary/cardiac rehab | 30% after deductible |
| Durable Medical Equipment | 20% after deductible; $0 diabetic supplies | 30% after deductible |
| Outpatient Mental Health | $35 | 30% after deductible |
| Inpatient Mental Health (190-day combined lifetime max) | $100/stay (days 1-10); 190-day lifetime max in a Medicare-approved facility | 30% after deductible |
| Physical Exams | $0 | 30% after deductible |
| Ob/Gyn Exams | $0 (routine every two years) | 30% |
| Mammograms | $0 | 30% |
| Skilled Nursing Facility | $0 days 1-20; $150 days 21-100 | 30% after deductible |
| Hearing Aids (once every 12 months)) | Covered under TruHearing; Standard $699 per ear; Premium $999 per ear | Not covered |
| Dental Care | Not covered | Not covered |
| Vision Exam | $35 | 30% after deductible |
| Hearing Exams | $35 | 30% |
| Prescription Lenses (once every 24 months) | $100 allowance for one pair of eyeglasses or contact lenses | $100 allowance for one pair of eyeglasses or contact lenses |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy | $24 non-preferred pharmacy |
| Preferred brand-name drugs (Tier 3) | $30 | $60 preferred pharmacy |
| Non-preferred brand-name drugs (Tier 4) | $50 | $100 preferred pharmacy |
| Specialty drugs (Tier 5) | 33% | 33% |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy | $24 non-preferred pharmacy |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% | 25% |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

| HOW MUCH YOU WILL PAY IN 2020 | INDEPENDENCE BLUE CROSS–KEYSTONE 65 SELECT HMO ($15/$20) | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | |
| Annual Deductible | $0 | |
| Annual Out-of-Pocket Maximum | $6,700 | |
| Hospitalization | $0 inpatient; $0 outpatient | |
| Doctor Visits | $15 PCP; $20 specialist | |
| Preventive Care | $0 | |
| Emergency Room | $40 (waived if admitted) | |
| Urgent Care Facility | $20 | |
| Outpatient Surgery | $0 | |
| Diagnostic Testing | $0 | |
| Outpatient Therapy | $20 ($5 pulmonary/cardiac rehab) | |
| Durable Medical Equipment | $0 | |
| Outpatient Mental Health | $20 per visit | |
| Inpatient Mental Health | $0; 190-day lifetime maximum in a Medicare-approved mental health facility | |
| Physical Exams | $0 | |
| Ob/Gyn Exams | $0 (routine every two years) | |
| Mammograms | $0 | |
| Skilled Nursing Facility | $0 days 1-100 | |
| Hearing Aids | Covered under TruHearing; Standard $699 per ear allowance; Premium $999 per ear allowance (once every 12 months) | |
| Dental Care | $15 cleaning/exam every 6 months | |
| Vision Exam/Hearing Exams | $20 | |
| Prescription Lenses (once every 24 months) | $0 for standard lenses and frames or contacts; 100% after $100 allowance for nonstandard frames or specialty contacts | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy | $24 preferred pharmacy |
| Preferred brand-name drugs (Tier 3) | $30 | $60 preferred pharmacy |
| Non-preferred brand-name drugs (Tier 4) | $50 may also include non-preferred generic drugs | $100 preferred pharmacy |
| Specialty drugs (Tier 5) | 33% | 33% |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $10 preferred pharmacy |
| Non-preferred generic drugs (Tier 2) | $12 preferred pharmacy; $17 standard pharmacy | $24 preferred pharmacy |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% | 25% |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

| HOW MUCH YOU WILL PAY IN 2020 | CAPITAL BLUECROSS BLUEJOURNEY PPO* | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $0 | $0 |
| Annual Out-of-Pocket Maximum | $3,400 (excludes Part D drugs and hearing) | $3,400 (excludes Part D drugs and hearing) |
| Hospitalization | $0 | 20% |
| Doctor Visits | $5 PCP; $0 virtual care; $15 specialist | $5 PCP; $15 specialist; virtual care not covered |
| Preventive Care | $0 | 20% |
| Emergency Room | $50 (waived if admitted) | $50 (waived if admitted) |
| Urgent Care Facility | $35 urgent care; $0 virtual care | $35 virtual care not covered |
| Outpatient Surgery | $0 | 20% |
| Diagnostic Testing | $10 lab services; $25 high-tech imaging; 15% therapeutic radiology; all other $0 | $10 lab services; $25 high-tech imaging; 15% therapeutic radiology, $0 all other |
| Outpatient Therapy | $15 | $15 |
| Durable Medical Equipment | 15% | 15% |
| Outpatient Mental Health | $15 | $15 |
| Inpatient Mental Health | $0 | 20% |
| Physical Exams | $0 (annual wellness exam) | 20% |
| Ob/Gyn Exams | $0 preventive screenings (once every 24 months) | 20% |
| Mammograms | $0 preventive screenings (once every 12 months) | 20% |
| Skilled Nursing Facility | $0 days 1-10; $25 days 11-100 | 20% |
| Hearing Aids (once every 36 months) | 100% after $500 allowance | 100% after $500 allowance |
| Dental Care | $15 office visit; cleaning and X-rays covered; 50% other services; $1,500 max per calendar year (in- and out-of-network combined) | 50%; $1,500 max per calendar year (in- and out-of-network combined) |
| Vision Exam/Hearing Exams | $15 copay for Medicare-covered hearing service | $15 copay for Medicare-covered services |
| Prescription Lenses (once every 24 months) | 100% after $40 allowance for frames | Lenses: 100% after dollar limit**<br>Frames: 100% after $40 limit |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $4 preferred pharmacy; $12 standard pharmacy | $12 preferred pharmacy; $36 standard pharmacy |
| Non-preferred generic drugs (Tier 2) | $4 preferred pharmacy; $12 standard pharmacy | $12 preferred pharmacy; $36 standard pharmacy |
| Preferred brand-name drugs (Tier 3) | $38 | $114 |
| Non-preferred brand-name drugs (Tier 4) | $90 | $270 |
| Specialty drugs (Tier 5) | 33% | Not covered |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | 25% | 25% |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | Not covered |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Capital BlueCross BlueJourney PPO is not available in Delaware or Maryland.

** Single lenses $36 allowance; Bifocal lenses $48 allowance; Trifocal lenses $58 allowance.

| HOW MUCH YOU WILL PAY IN 2020 | AETNA MEDICARE P01 | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $0 | $0 |
| Annual Out-of-Pocket Maximum | $3,500 | $5,000 |
| Hospitalization | $0 | 15% |
| Doctor Visits | $15 | 15% |
| Preventive Care | $0 | 15% |
| Emergency Room | $50 (waived if admitted) | $50 (waived if admitted) |
| Urgent Care Facility | $15 | $15 |
| Outpatient Surgery | $0 | 15% |
| Diagnostic Testing | $15 | 15% |
| Outpatient Therapy | $15 | 15% |
| Durable Medical Equipment | 15% | 15% |
| Outpatient Mental Health | $15 | 15% |
| Inpatient Mental Health | $0 | 15% |
| Physical Exams | $0 | 15% |
| Ob/Gyn Exams | $0 | 15% |
| Mammograms | $0 | 15% |
| Skilled Nursing Facility | $0 copay per day, day(s) 1-20; $75 per day, day(s) 21-100 | 15% |
| Hearing Aids (once every 36 months) | $500 allowance | |
| Dental Care | Non-routine care covered by Medicare | Non-routine care covered by Medicare |
| Vision Exam/Hearing Exams | $0 (once every 12 months) | 15% (once every 12 months) |
| Prescription Lenses (once every 24 months) | $100 allowance | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 | $10 |
| Non-preferred generic drugs (Tier 2) | $5 | $10 |
| Preferred brand-name drugs (Tier 3) | $25* | $50* |
| Non-preferred brand-name drugs (Tier 4) | $50* | $100* |
| Specialty drugs (Tier 5) | 33% | 33% (limited to one-month supply) |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | $5 | $10 |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Copay also applies to some high-cost generics.

| HOW MUCH YOU WILL PAY IN 2020 | HIGHMARK SECURITY BLUE HMO POINT-OF-SERVICE | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | **Out-of-Network** |
| Annual Deductible | $0 | $0 |
| Annual Out-of-Pocket Maximum | $3,400 | $10,000 (combined in- and out-of-network) |
| Hospitalization | $0 | $0 |
| Doctor Visits | $10 PCP; $20 specialist | $10 PCP; $20 specialist |
| Preventive Care | $0 | $0 |
| Emergency Room | $50 (waived if admitted) | $50 (waived if admitted) |
| Urgent Care Facility | $40 | $40 |
| Outpatient Surgery | $0 | $0 |
| Diagnostic Testing | $0 | $0 |
| Outpatient Therapy | $20 | $20 |
| Durable Medical Equipment | 15% | Not covered |
| Outpatient Mental Health | $20 | $20 |
| Inpatient Mental Health | $0 | $0 |
| Physical Exams | $0 (office visit copay may apply) | $0 (office visit copay may apply) |
| Ob/Gyn Exams | $0 (office visit copay may apply) | $0 (office visit copay may apply) |
| Mammograms | $0 | $0 |
| Skilled Nursing Facility | $0 up to 100 days per Medicare benefit period | $0 up to 100 days per Medicare benefit period |
| Hearing Aids | $0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium | Not covered |
| Dental Care | $20 for exam, cleaning and X-rays every 6 months; 50% for restorative services: 50% for dentures every 5 years | Not covered |
| Vision Exam/Hearing Exams | $0 vision; $20 hearing | Not covered |
| Prescription Lenses | 100% after a $100 benefit maximum per calendar year for standard eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full (annually) | Not covered |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (31-day supply)** | **Mail Order (90-day supply)*** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Non-preferred generic drugs (Tier 2) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Preferred brand-name drugs (Tier 3) | $25 preferred pharmacy; $30 standard pharmacy | $62.50 |
| Non-preferred brand-name drugs (Tier 4) | $55 preferred pharmacy; $60 standard pharmacy | $137.50 |
| Specialty drugs (Tier 5) | 33% | Not covered |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | $5 preferred pharmacy; $10 standard pharmacy | $12.50 preferred pharmacy only |
| Brand-name drugs (Tiers 3 & 4) | Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%) | 20% (plan pays 10% and manufacturer discounts 70%) |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | Not covered |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |

* Must obtain mail order supply using Express Scripts/ESI.

| HOW MUCH YOU WILL PAY IN 2020 | CAPITAL BLUECROSS BLUEJOURNEY HMO | |
|---|---|---|
| **MEDICAL PLAN** | **In-Network** | |
| Annual Deductible | $0 | |
| Annual Out-of-Pocket Maximum | $3,400 (excludes Part D drugs and hearing) | |
| Hospitalization | $100/admission ($200 max) | |
| Doctor Visits | $15 PCP; $25 specialist | |
| Preventive Care | $0 | |
| Emergency Room | $80 (waived if admitted) | |
| Urgent Care Facility | $35 | |
| Outpatient Surgery | $75 | |
| Diagnostic Testing | $15 lab services; $50 high-tech imaging; 20% therapeutic radiology; $0 other | |
| Outpatient Therapy | $25 | |
| Durable Medical Equipment | 20% | |
| Outpatient Mental Health | $25 | |
| Inpatient Mental Health | $100/admission ($200 max) | |
| Physical Exams | $0 (wellness exam; 1 per year) | |
| Ob/Gyn Exams | $0 (cervical and vaginal cancer screening) | |
| Mammograms | $0 (breast cancer screening; 1 per year) | |
| Skilled Nursing Facility | $0 days 1-10; $20 days 11-20; $50 days 21-100 | |
| Hearing Aids (once every 36 months) | 100% after $400 allowance | |
| Dental Care | $15 office visit; cleaning and X-rays covered; 50% for other covered dental services; $1,500 allowance per year | |
| Vision Exam | $20 vision | |
| Hearing Exams | $25 Medicare-covered services; $0 routine hearing exam | |
| Prescription Lenses (once every 24 months) | $0 lenses | |
| **PRESCRIPTION DRUGS** | **Retail Pharmacy (30-day supply)** | **Mail Order (90-day supply)** |
| Annual Deductible | $0 | $0 |
| Initial Coverage Up to a Total Drug Cost of $4,020 | | |
| Preferred generic drugs (Tier 1) | $4 | $12 |
| Non-preferred generic drugs (Tier 2) | $12 | $36 |
| Preferred brand-name drugs (Tier 3) | $38 | $114 |
| Non-preferred brand-name drugs (Tier 4) | $90 | $270 |
| Specialty drugs (Tier 5) | 33% | Not covered |
| Coverage Gap to TrOOP Maximum of $6,350 | | |
| Generic drugs (Tiers 1 & 2) | 25% | 25% |
| Brand-name drugs (Tiers 3 & 4) | 25% (plan pays 5% and manufacturer discounts 70%) | |
| Specialty drugs (Tier 5) | 25% (plan pays 5% and manufacturer discounts 70%) | Not covered |
| Catastrophic Coverage | | |
| Generic drugs | The greater of 5% or $3.60 | |
| Brand-name drugs | The greater of 5% or $8.95 | |