HOW MUCH YOU WILL PAY IN 2020	HOP PRE-65 MEDICAL PLAN	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$1,500	
Annual Out-of-Pocket Maximum	$5,500	
Annual Benefit Maximum	$300,000	
Hospitalization	25%	40%
Doctor Visits	25%	40%
Preventive Care	$0	40%
Emergency Room	25%	25% (40% if not a true emergency)
Urgent Care Facility	25%	40%
Outpatient Surgery	25%	40%
Diagnostic Testing	25%	40%
Outpatient Therapy	25%	40%
Durable Medical Equipment	25%	40%
Outpatient Mental Health	25%	40%
Inpatient Mental Health	25%	40%
Physical Exams	$0*	40%*
Ob/Gyn Exams	$0*	40%*
Mammograms	$0*	40%*
Skilled Nursing Facility	25%	40%
Hearing Aids (once every 24 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 36 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$350	
Annual Maximum	After plan pays $3,000 for all prescription drugs, you pay 100% for non-Critical Care brand-name drugs	
Retail Pharmacy		
Generic drugs	50%	50% of cost at a network pharmacy + 100% of excess
Brand-name drugs	50% Critical Care; $100 maximum/ prescription	50% of cost at a network pharmacy + 100% of excess
Mail Order (90-day supply)		
Generic drugs	50%	Not covered
Brand-name drugs	50% Critical Care-$300 maximum/ prescription	Not covered

* For specific services and subject to a $300 total annual maximum benefit

HOW MUCH YOU WILL PAY IN 2020	HOP PRE-65 MEDICAL PLAN	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$1,500	
Annual Out-of-Pocket Maximum	$5,500	
Annual Benefit Maximum	$300,000	
Hospitalization	25%	40%
Doctor Visits	25%	40%
Preventive Care	$0	40%
Emergency Room	25%	25% (40% if not a true emergency)
Urgent Care Facility	25%	40%
Outpatient Surgery	25%	40%
Diagnostic Testing	25%	40%
Outpatient Therapy	25%	40%
Durable Medical Equipment	25%	40%
Outpatient Mental Health	25%	40%
Inpatient Mental Health	25%	40%
Physical Exams	$0*	40%*
Ob/Gyn Exams	$0*	40%*
Mammograms	$0*	40%*
Skilled Nursing Facility	25%	40%
Hearing Aids (once every 24 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 36 months)	Not covered	Not covered

* For specific services and subject to a $300 total annual maximum benefit

HOW MUCH YOU WILL PAY IN 2020	AETNA PREMIER OPEN CHOICE PPO*	
MEDICAL	**In-Network Only**	**Out-of-Network**
Annual Deductible	$300/individual $600/family	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$6,600/individual $13,200/family	$10,000/individual $20,000/family
Hospitalization	$200/day to $1,000/admission maximum	30%
Doctor Visits	$15/visit PCP; $40/visit specialist	30%
Preventive Care	$0; no deductible	30%
Emergency Room	$75; no deductible (waived if admitted)	$75; no deductible (waived if admitted)
Urgent Care Facility	$50; no deductible	30%
Outpatient Surgery	$150	30%
Diagnostic Testing	$35 X-ray/lab; $150 complex	40%
Outpatient Therapy	$40	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40; all other mental health $0	30%
Inpatient Mental Health	$200/day to $1,000/admission maximum	30%
Physical Exams	0%; no deductible; routine	30%
Ob/Gyn Exams	0%; no deductible; routine	30%
Mammograms	0%; no deductible; routine	30%
Skilled Nursing Facility	$100/day to $500, then $0; after deductible; 100-day limit	30%
Hearing Aids (once every 36 months)	100% after $1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: $0; 1 exam/12 months; Hearing: $40; 1 exam/24 months	30%
Prescription Lenses (once every 24 months)	100% after $100 allowance	100% after $100 allowance
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%-formulary 50%-non-formulary	Not covered

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

HOW MUCH YOU WILL PAY IN 2020	HIGHMARK PPOBLUE (80-70 PLAN)	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$10,000	No maximum
Hospitalization	20%	30%
Doctor Visits	$20/visit PCP; $40/visit specialist	30%
Preventive Care	$20/visit	Routine physicals not covered; 70% for routine gynecological and mammograms
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)
Urgent Care Facility	$40	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; 60-visit maximum*	30% to 60-visit maximum*
Durable Medical Equipment	20%	30%
Outpatient Mental Health	0%; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	$20/visit PCP; $40/visit specialist	Not covered
Ob/Gyn Exams	$40/visit	30% routine (no deductible)
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	Not covered
Annual Maximum	No maximum	Not covered
Retail Pharmacy		
Generic drugs	30% (mandatory generic)**	Not covered
Brand-name drugs	50%**	Not covered
Mail Order (90-day supply)		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered

* Combined in- and out-of-network maximum

** 34-day supply.

HOW MUCH YOU WILL PAY IN 2020	AETNA VALUE OPEN CHOICE PPO*	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$1,500/individual $3,000/family	$1,500/individual $3,000/family
Annual Out-of-Pocket Maximum	$4,000/individual $8,000/family	$4,000/individual $8,000/family
Hospitalization	20%	40%
Doctor Visits	20%; no deductible	40%
Preventive Care	$0; no deducible	40%
Emergency Room	20%; no deductible	20%; no deductible
Urgent Care Facility	20%	40%
Outpatient Surgery	20%; no deductible	40%
Diagnostic Testing	20% X-ray/lab; $50 complex	40%
Outpatient Therapy	20%; no deductible	40%
Durable Medical Equipment	50%	50%
Outpatient Mental Health	20%; no deductible	40%
Inpatient Mental Health	20%	40%
Physical Exams	0%; no deductible; routine	40%
Ob/Gyn Exams	0%; no deductible; routine	40%
Mammograms	0%; no deductible; routine	40%
Skilled Nursing Facility	20%; 120 day limit	40%; 120 day limit
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	0%; no deductible for Vision; 1 per 24 months. 0%; no deductible for Hearing	40%
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%-formulary 50%-non-formulary	Not covered

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

HOW MUCH YOU WILL PAY IN 2020	UPMC HEALTH PLAN EPO*
MEDICAL	**In-Network Only**
Annual Deductible	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$4,000/individual $8,000/family
Hospitalization	20%
Doctor Visits	$20/visit PCP; $40/visit specialist
Preventive Care	$0
Emergency Room	$100 copay (waived if admitted)
Urgent Care Facility	$40
Outpatient Surgery	20%
Diagnostic Testing	20%
Outpatient Therapy	$40/visit; 30-visit maximum
Durable Medical Equipment	20%
Outpatient Mental Health	$40/visit
Inpatient Mental Health	20%
Physical Exams	$0 routine
Ob/Gyn Exams	$0 routine
Mammograms	$0 routine
Skilled Nursing Facility	20%; 120 days per benefit period
Hearing Aids (once every 36 months)	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses (once every 24 months)	Not covered
PRESCRIPTION DRUGS	
Annual Deductible	$0
Annual Maximum	No maximum
Retail Pharmacy	
Generic drugs	$8 (mandatory generic)
Brand-name drugs	$38/preferred; $76/non-preferred and specialty
Mail Order (90-day supply)	
Generic drugs	$16 (mandatory generic)
Brand-name drugs	$76/preferred; $152/non-preferred

* UPMC is not available in all counties.

HOW MUCH YOU WILL PAY IN 2020	INDEPENDENCE BLUE CROSS POS $20-$40/$250	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$5,000/individual $10,000/family
Annual Out-of-Pocket Maximum	$7,350/individual $14,700/family	$30,000/individual $60,000/family
Hospitalization	$250/day to $1,250/admission maximum	50%
Doctor Visits	$20/visit PCP; $40/visit specialist	50%
Preventive Care	$0	50%
Emergency Room	$250 (not waived if admitted)	$250 (not waived if admitted); no deductible
Urgent Care Facility	$85	50%
Outpatient Surgery	$250	50%
Diagnostic Testing	$0 outpatient lab/pathology; $40 outpatient X-ray and routine/diagnostic radiology; $80 complex radiology	50%
Outpatient Therapy	$40	50%
Durable Medical Equipment	50%	50%
Outpatient Mental Health	$40	50%
Inpatient Mental Health	$250/day to $1,250/admission maximum	50%
Physical Exams	$20/visit PCP; $40/visit specialist	50%
Ob/Gyn Exams	$0	50%
Mammograms	$0	50%
Skilled Nursing Facility	$125/day max $625 copay; 120 days per calendar year	50%; 60 days per calendar year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	$35 for vision; 1 per 24 months Hearing not covered	Not covered
Prescription Lenses (once every 24 months)	$65 frame allowance at participating provider; $0 Davis Collection frames. $100 allowance on contacts in lieu of glasses.	Up to $100 reimbursement for lenses/ frames and contacts
PRESCRIPTION DRUGS		
Annual Deductible	$0	$0
Annual Maximum	No maximum	No maximum
Retail Pharmacy		
Generic drugs	$5-low cost generic $20-generic	70% of drug retail cost
Brand-name drugs	$40-preferred $60-non-preferred	70% of drug retail cost
Mail Order (90-day supply)		
Generic drugs	$10-low cost generic $40-generic	70% of drug retail cost
Brand-name drugs	$80-preferred $120-non-preferred	70% of drug retail cost

HOW MUCH YOU WILL PAY IN 2020	AETNA HMO PLAN
MEDICAL	**In-Network Only**
Annual Deductible	$0
Annual Out-of-Pocket Maximum	$1,500/individual; $3,000/family
Hospitalization	$0
Doctor Visits	$10 PCP; $15 specialist
Preventive Care	$0
Emergency Room	$35 (waived if admitted)
Urgent Care Facility	$35
Outpatient Surgery	$0
Diagnostic Testing	$0 lab; $15 X-ray, complex
Outpatient Therapy	$15
Durable Medical Equipment	$0
Outpatient Mental Health	$0
Inpatient Mental Health	$0
Physical Exams	$0 routine
Ob/Gyn Exams	$0 routine
Mammograms	$0 routine
Skilled Nursing Facility	$0; limit 120 days
Hearing Aids (once every 36 months)	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	$0 routine eye; $0 routine hearing
Prescription Lenses (once every 24 months)	100% after $100 allowance
PRESCRIPTION DRUGS	
Annual Deductible	$0
Annual Maximum	Combined with medical
Retail Pharmacy	
Generic drugs	30%
Brand-name drugs	30%-formulary 50%-non-formulary
Mail Order (90-day supply)	
Generic drugs	30%
Brand-name drugs	30%-formulary 50%-non-formulary

HOW MUCH YOU WILL PAY IN 2020	INDEPENDENCE BLUE CROSS-PERSONAL CHOICE PPO	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$6,600/individual $13,200/family	$3,000/individual $6,000/family
Hospitalization	$100/day; maximum $500/admission	30%
Doctor Visits	$15/visit PCP; $25/visit specialist	30%
Preventive Care	$0	30%, no deductible
Emergency Room	$40 (waived if admitted)	$40, no deductible (waived if admitted)
Urgent Care Facility	$28	30%
Outpatient Surgery	$100	30%
Diagnostic Testing	$0 outpatient lab/pathology; $25 outpatient X-ray/radiology	30%
Outpatient Therapy	PT/OT/SP $15 visits 1-30; $25 visits 31-60; 60-visit max per year for PT/OT/Speech combined Cardiac 36 visits per year Pulmonary 12 visits per year	30%
Durable Medical Equipment	$25	30%
Outpatient Mental Health	$25	30%
Inpatient Mental Health	$100/day; maximum $500/admission	30%
Physical Exams	$15 PCP; $25 specialist	30%
Ob/Gyn Exams	$0 routine gyn; $15 initial ob office visit	30%, no deductible
Mammograms	$0	30%, no deductible
Skilled Nursing Facility	$0; limit 120 days per year	30%, no deductible; limit 120 days per year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	$10 vision; hearing not covered	Up to $40 reimbursement for vision; hearing not covered
Prescription Lenses (once every 24 months)	$25 Spectacle lenses. $100 allowance on frames at participating provider (plus 20% discount on overage). Davis Collection frames: $0 fashion, $15 designer, $40 premier. $150 allowance (plus 20% discount on overage) at Visionworks. Contacts in lieu of glasses: $100 allowance (plus 15% discount on overage).	$50 frames; $40 single vision lenses; $60 bifocal/progressive lenses; $80 trifocal lenses; $100 lenticular lenses; $80 contact lenses; $225 medically necessary contact lenses
PRESCRIPTION DRUGS		
Annual Deductible	$0	$0
Annual Maximum	No maximum	No maximum
Retail Pharmacy (34-day supply)		
Generic drugs	50%	50% of drug retail cost
Brand-name drugs	50%	50% of drug retail cost
Mail Order (90-day supply)		
Generic drugs	50%	50% of drug retail cost
Brand-name drugs	50%	50% of drug retail cost

HOW MUCH YOU WILL PAY IN 2020	CAPITAL BLUECROSS PPO	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$3,000/individual $6,000/family	No maximum
Hospitalization	20%	30%
Doctor Visits	$10/PCP visit; $25/specialist visit	30%
Preventive Care	$10/visit	20%
Emergency Room	$100; no deductible (waived if admitted)	$100; no deductible (waived if admitted)
Urgent Care Facility	$40; no deductible	30%; no deductible
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; no deductible	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40/visit; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	$10/PCP visit; $25/specialist visit; no deductible	20%
Ob/Gyn Exams	$0; no deductible	30%, no deductible
Mammograms	$0; no deductible	30%, no deductible
Skilled Nursing Facility	$0; limit 100 days	50%; limit 100 days
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$300/individual $600/family	Not covered
Annual Maximum	$2,500 benefit period maximum on lifestyle drugs	Not covered
Retail Pharmacy		
Generic drugs	30%*	Not covered
Brand-name drugs	30%/preferred;* 50%/non-preferred	Not covered
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%/preferred; 50%/non-preferred	Not covered

* Specialty generic drugs are covered at 30%, Specialty brand preferred drugs are covered at 50%, and Specialty brand non-preferred drugs are not covered.

HOW MUCH YOU WILL PAY IN 2020	HIGHMARK PPOBLUE (HIGH OPTION)	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$250/individual; $500/family
Annual Out-of-Pocket Maximum	No maximum	$1,000/individual $2,000/family
Hospitalization	$0	20%
Doctor Visits	$10/visit	20%
Preventive Care	$10/visit	Not covered
Emergency Room	$25 (waived if admitted)	$25 (waived if admitted)
Urgent Care Facility	$10	20%
Outpatient Surgery	$0	20%
Diagnostic Testing	$0	20%
Outpatient Therapy	$0 to 60-visit maximum*	20% to 60-visit maximum*
Durable Medical Equipment	$0	20%
Outpatient Mental Health	$0	20%
Inpatient Mental Health	$0	20%
Physical Exams	$10	Not covered
Ob/Gyn Exams	$10	20% routine (no deductible)
Mammograms	$0	20%
Skilled Nursing Facility	$0; limit 100 days per calendar year	20%; limit 100 days per year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision exam–$10 (once every 24 months for members over age 18) Hearing Exam–Not covered	Vision exam–20% (once every 24 months) Hearing Exam–Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	Not covered
Annual Maximum	No maximum	Not covered
Retail Pharmacy (34-day supply)		
Generic drugs	$8 (mandatory generic)	Not covered
Brand-name drugs	$14	Not covered
Mail Order (90-day supply)		
Generic drugs	$16 (mandatory generic)	Not covered
Brand-name drugs	$28	Not covered

* Combined in- and out-of-network maximum.