

Medical and Prescription Comparison Chart

BENEFITS	Plan A Premium or Standard PPO		Plan B Premium or Standard PPO		HDHP+ High Deductible Health Plan + Premium or Standard	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Deductible (per calendar year) Individual (Employee Only for HDHP+) Family (Employee +1 or Family for HDHP+)	\$300 \$600	\$600 \$1,800	\$600 \$1,200	\$1,200 \$3,600	\$2,000 \$4,000	\$3,000 \$6,000
Plan Payment Level Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%	80% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%	100% after deductible	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	\$2,100 \$4,200	\$4,200 \$12,600	\$3,600 \$7,200	\$7,200 \$21,600	None after deductible	\$2,800 \$5,600
Lifetime Maximum (per member)	Unlimited		Unlimited		Unlimited	
Physician Office Visits¹ Specialist Office Visits (Including allergy injections)	100% after \$25 copay deductible does not apply 100% after \$35 copay deductible does not apply	60% after deductible	100% after \$25 copay deductible does not apply 100% after \$35 copay deductible does not apply	60% after deductible	100% after deductible (preventative services 100%, nondeductible)	60% after deductible until out-of-pocket is met; then 100%
Preventive Care² Routine physical, gynecological exams, mammograms, annual routine exam, or as recommended by physician	100%; deductible does not apply	Not covered	100%; deductible does not apply	Not covered	100%; deductible does not apply	Not covered
Adult and pediatric immunizations	100%; deductible does not apply	Not covered	100%; deductible does not apply	Not covered	100%; deductible does not apply	Not covered
Diagnostic Services Basic Diagnostic Services (Lab, x-ray, allergy testing, and other diagnostic tests)	100%; deductible does not apply	60% after deductible	100%; deductible does not apply	60% after deductible	100% after deductible	60% after deductible
Advanced Imaging Services (MRI, CAT scan, PET scan, etc.)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Colorectal Cancer Screening	100% every 10 years beginning at age 50, whether routine or medical; deductible does not apply	60% after deductible	100% every 10 years beginning at age 50, whether routine or medical; deductible does not apply	60% after deductible	100% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Hospital Services – Inpatient³	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Precertification Requirements (Inpatient Only) Performed by Member	Required or \$300 reduction in benefits	Required or \$500 reduction in benefits	Required or \$300 reduction in benefits	Required or \$500 reduction in benefits	Required or \$300 reduction in benefits	Required or \$500 reduction in benefits
Maternity (all services)	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Physical, Speech, and Occupational Therapy	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Acupuncturists, Chiropractors, and Massage Therapists	Combined Limit: 20 visits per calendar year		Combined Limit: 20 visits per calendar year		Combined Limit: 20 visits per calendar year	
	100% after \$35 copay; deductible does not apply Combined Limit: \$500 maximum per calendar year per individual \$1,500 maximum per calendar year per family	Same as network services, but Usual/Customary charges apply	100% after \$35 copay; deductible does not apply Combined Limit: \$500 maximum per calendar year per individual \$1,500 maximum per calendar year per family	Same as network services, but Usual/Customary charges apply	Chiropractic benefits only 100% after deductible 60% after deductible; but Usual/Customary charges apply Combined Limit: \$500 maximum per calendar year per individual \$1,500 maximum per calendar year per family	
Mental Health Care Services/Substance Abuse Services — Outpatient (including marital counseling)	100% after \$25 copay; deductible does not apply	60% after deductible	100% after \$25 copay; deductible does not apply	60% after deductible	100% after deductible	60% after deductible
Mental Health Care Services/Substance Abuse Services — Inpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible	100% after deductible	60% after deductible
PRESCRIPTION DRUGS	RETAIL PHARMACY	MAIL ORDER	RETAIL PHARMACY	MAIL ORDER	RETAIL PHARMACY	MAIL ORDER
Deductible	\$50 per individual; \$100 per family		\$50 per individual; \$100 per family		Subject to medical deductible before the below benefits apply	
Days' Supply	30	90	30	90	30	90
Generic	25% or co-pay maximum of \$10	25% or co-pay maximum of \$20	25% or co-pay maximum of \$10	25% or co-pay maximum of \$20	100% after deductible	100% after deductible
Brand	25% or co-pay maximum of \$40	25% or co-pay maximum of \$80	25% or co-pay maximum of \$40	25% or co-pay maximum of \$80	100% after deductible	100% after deductible
Brand with generic available	25% or co-pay maximum of \$40 + cost difference	25% or co-pay maximum of \$80 + cost difference	25% or co-pay maximum of \$40 + cost difference	25% or co-pay maximum of \$80 + cost difference	100% after deductible	100% after deductible
Non Formulary Brand	25% or co-pay maximum of \$60	25% or co-pay maximum of \$120	25% or co-pay maximum of \$60	25% or co-pay maximum of \$120	100% after deductible	100% after deductible
Non Formulary Brand with generic available	25% or co-pay maximum of \$60 + cost difference	\$80 copay + difference in cost	25% or co-pay maximum of \$60 + cost difference	25% or co-pay maximum of \$120 + cost difference	100% after deductible	100% after deductible
Specialty Drugs	25% or co-pay maximum of \$200		25% or co-pay maximum of \$200		100% after deductible	

1 Some services performed in the doctor's office are subject to a deductible or are not covered.

2 Preventive Care: In order for your claim to be paid as "Preventive" or "Wellness," you must use PPO provider(s) and the service must conform to the Preventive Schedule available by logging in at www.highmarkbcbs.com or call the member service number on your I.D. card. The provider(s) must code the claim as "Wellness" or "Routine Preventive."

3 You are required to contact Highmark Healthcare Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. 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.

Important Note: This is not intended as a contract of benefits. It is designed purely as a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Employee Benefits Booklet (a 98-page document accessible on our Benefits Web site) provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Benefits Summary and your Employee Benefits Booklet, the Benefits Booklet will govern.