Post-65 Medical Plans Comparative Summary of Key Provisions

	UPMC FOR LIFE (HMO)		UPMC FOR LIFE - STANDARD (PPO)		UPMC FOR LIFE - BASIC (PPO)		HIGHMARK FREEDOM BLUE - STANDARD (PPO)		UPMC NATIONAL COMPLEMENTARY PLAN (Supplementary Plan)		HIGHMARK SIGNATURE 65 WITH BLUE RX (Supplementary Plan)	
	IN-NETWORK	OUT-of-NETWORK	IN-NETWORK	OUT-of-NETWORK	IN-NETWORK	OUT-of-NETWORK	IN-NETWORK	OUT-of-NETWORK	IN-NETWORK	OUT-of-NETWORK	IN-NETWORK	OUT-of-NETWORK
Deductible	*$0*		*$0*	*$500*	*$250*	*$500*	*$0*		*n/a*		*Current Medicare Part B Deductible*	
Out-of-Pocket Max	*$3,400*		*$3,400*	*$5,100*	*$1,000*	*$3,400*	*In-network: $3,400 Combined: $3,400*		*n/a*			
Preventive Services, Inpatient Care, Outpatient Care, and Supplemental Benefits												
Immunizations	*$0*		*$0*		*$0*		*$0*		*You pay $100 inpatient deductible on your first hospital stay per year.* *UPMC pays 100% of medically necessary costs after the primary carrier has paid and the $100 deductible has been met.*		*$0 after Medicare Part B Deductible*	
Annual Wellness Visit							*$15*					
Inpatient Hospital/Mental Health Care	*$50 copay per stay*		*$250 copay per stay*		*10% coinsurance per stay*		*$50*					
Skilled Nursing Facility *Days 1-100; 100 day limit*	*$0*		*$0 copay (days 1-20) $25 copay (days 21-100)*				*$25 (days 16-55)*		*For days 1-100, UPMC pays for 100% of medically necessary costs after the primary carrier has paid.* *You pay all costs for days 101 and after that, per the benefit period.*		*$0 days 1-150*	
Home Health Care	*$0*		*$0*		*$0*		*$0*		*UPMC pays 100% of medically necessary costs after the primary carrier has paid.*		*$0 after Medicare Part B Deductible*	
Primary Care Physician Visits and Telehealth	*$15*		*$20*		*$20*		*$15*					
Specialists Visits	*$20*		*$20*		*$20*		*$20*					
Emergency Care *(Waived if admitted within 3 days)*	*$75*		*$75*		*$75*		*$50*					
Urgently Needed Care *(Clinics)*	*$20*		*$20*		*$20*		*$40*					
Outpatient Rehab Services *(PT, OT, ST)*	*$20*		*$20*		*10% coinsurance*		*$20*					
Lab Services *(Per day, per facility)*	*$0*		*$0*		*$0*		*0% coinsurance*					
Diagnostic X-Ray Services *(Basic imaging, per service)*	*$0*		*$0*		*$0*		*0% coinsurance*					
Dental Cleaning/Oral Exam *(Two cleanings per year)*	*$0 cleaning; $20 exam*		*$0 cleaning; $20 exam*		*$0 cleaning; $20 exam*		*Not covered*		*Not covered*		*Not covered*	
Hearing Exam	*$20*		*$20*		*$20*		*$20*		*$25*		*Not covered*	
Hearing Aids	*$690-$1,890 copay, per aid*		*$690-$1,890 copay, per aid*		*$690-$1,890 copay, per aid*		*TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid (up to 2 hearings aids per year; there is a $500 allowance every 3 years for any other hearing aids through TruHearing®*		*$690-$1,890 copay, per aid*		*Hearing aid discounts offered through Blue 365*	
Vision Exam/Eyewear *(One every year)*	*$20 exam copay, $250 eyewear allowance*		*$0 exam, $250 eyewear allowance*		*$0 exam, $250 eyewear allowance*		*$0 for Collection frames and standard lenses; $150 benefit maximum for all others*	*$150 benefit maximum towards the purchase of frames and lenses*	*$0 exam, $250 eyewear allowance*		*Not covered*	
SilverSneakers (UPMC) FitOn (Highmark)	*Covered*		*Covered*		*Covered*		*Covered*	*50% coinsurance after $500 deductible*	*Covered*		*Gym discounts offered through Blue 365*	

Revised 10/23