Summary of Benefits – Option A

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $750
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,500 $3,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $10 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $10 copayment	80% after deductible
Specialist Office Visits	100% after $10 copayment	80% after deductible
Urgent Care Center Visits	100% after $10 copayment	80% after deductible
Preventive Care(2)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $35 copayment (waived if admitted)	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Respiratory Therapy	100%	
Speech & Occupational Therapy	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Spinal Manipulations	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	80% after deductible
Outpatient	100%	80% after deductible

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care		
Hospice		
Infertility Counseling, Testing and Treatment(3)		
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible Limit: 100 days/benefit period
Transplant Services	100%	80% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (31-day Supply)** 20% coinsurance or $50 maximum per prescription whichever is less **Maintenance Drugs through Mail Order (90-day Supply)** 20% coinsurance or $50 maximum per prescription whichever is less	

Questions? Call 1-800-215-7865

Reference Code: P0200511

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(5) You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

Summary of Benefits – Option B

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $500 $1,000	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $20 copayment	60% after deductible
Primary Care Provider Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $20 copayment	60% after deductible
Urgent Care Center Visits	100% after $20 copayment	60% after deductible
Preventive Care(2)		
Routine Adult Physical exams	 100% (deductible does not apply)	 Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	80% after deductible	60% after deductible
Emergency Services		
Emergency Room Services	100% after $50 copayment (waived if admitted)	
Ambulance	80% after Network deductible	
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible Limit: 20 visits/benefit period	60% after deductible
Respiratory Therapy	80% after Network deductible	
Speech & Occupational Therapy	80% after deductible Limit: 20 visits per therapy/benefit period	60% after deductible
Spinal Manipulations	80% after deductible Limit: 20 visits/benefit period	60% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care		
Hospice		
Infertility Counseling, Testing and Treatment(3)		
Private Duty Nursing	80% after Network deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible Limit: 100 days/benefit period
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (31-day Supply)** 20% coinsurance or $50 maximum per prescription, whichever is less **Maintenance Drugs through Mail Order (90-day Supply)** 20% coinsurance or $50 maximum per prescription, whichever is less	

Questions? Call 1-800-215-7865

Reference Code: P0210511

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(5) You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

Summary of Benefits – Option E

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,000 $2,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $5 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $5 copayment	80% after deductible
Specialist Office Visits	100% after $5 copayment	80% after deductible
Urgent Care Center Visits	100% after $5 copayment	80% after deductible
Preventive Care(2)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $20 copayment (waived if admitted)	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100%	80% after deductible
Respiratory Therapy	100%	
Speech & Occupational Therapy	100%	80% after deductible
Spinal Manipulations	100% after $5 copayment	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	80% after deductible
Outpatient	100%	80% after deductible

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care		
Hospice		
Infertility Counseling, Testing and Treatment(3)		
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (34-day Supply or 100 dosage unit whichever is greater)** $5 generic copayment $10 brand copayment **Maintenance Drugs through Mail Order (60-day Supply)** $6 generic copayment $12 brand copayment	

Questions? Call 1-800-215-7865

Reference Code: P0220511

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(5) You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

Summary of Benefits – Option F

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,000 $2,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $5 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $5 copayment	80% after deductible
Specialist Office Visits	100% after $5 copayment	80% after deductible
Urgent Care Center Visits	100% after $5 copayment	80% after deductible
Preventive Care(2)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100%	80% after deductible
Emergency Services		
Emergency Room Services	100%	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100%	80% after deductible
Respiratory Therapy	100%	
Speech & Occupational Therapy	100%	80% after deductible
Spinal Manipulations	100% after $5 copayment	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	80% after deductible
Outpatient	100%	80% after deductible

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care		
Hospice		
Infertility Counseling, Testing and Treatment(3)		
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (34-day Supply or 100 dosage unit whichever is greater)** $5 generic copayment $10 brand copayment **Maintenance Drugs through Mail Order (60-day Supply)** $6 generic copayment $12 brand copayment	

Questions? Call 1-800-215-7865

Reference Code: P0230511

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(5) You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

Summary of Benefits – Option G

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $500 $1000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,500 $3,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $10 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $10 copayment	80% after deductible
Specialist Office Visits	100% after $10 copayment	80% after deductible
Urgent Care Center Visits	100% after $10 copayment	80% after deductible
Preventive Care(2)		
Routine Adult Physical exams	 100% (deductible does not apply)	 Not Covered
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $35 copayment (waived if admitted)	
Ambulance	100% after network deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Respiratory Therapy	100%	
Speech & Occupational Therapy	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Spinal Manipulations	100% after $10 copayment Limit: 20 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100% after deductible	80% after deductible
Outpatient	100% after deductible	80% after deductible

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care		
Hospice		
Infertility Counseling, Testing and Treatment(3)		
Private Duty Nursing	100% after network deductible	
Skilled Nursing Facility Care	100% after deductible	80% after deductible Limit: 100 days/benefit period
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program(5) Mandatory Generic *Defined by the Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (31-day Supply)** $5 generic copayment $15 formulary brand copayment $30 non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copayment $30 formulary brand copayment $60 non-formulary copayment	

Questions? Call 1-800-215-7865

Reference Code: P0240511

(Please have your Reference Code ready when you call)

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
(5) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply

Health Insurance Waiver

Name: _____
(Please Print)

This is to notify Penn-Trafford School District that I wish to cancel/opt-out of the Health Insurance package offered to me by the district. This includes Blue Cross/Blue Shield PPO coverage, Dental and Vision Insurances.

If you choose to opt out of the district benefits you must provide proof of health care coverage.

I understand that by doing this I cannot enroll until the open enrollment period (May) for the coverage period beginning July of each year.

You may qualify to re-enroll in the benefits plan should a life changing event occur such as marriage, birth of a child, spousal plan lose of benefits, etc.

_____ _____
Employee Signature Date

cc: Personnel File
Payroll Department/Benefit File