Residents of the following counties: Allegheny, Beaver, Butler, Greene, Fayette, Washington, Westmoreland, <u>please click here</u>.

Residents of the following counties: Armstrong, Cambria, Indiana, please click here.

Residents of the following counties: Crawford, Erie, Forest, McKean, Mercer, Venango, Warren, please click here.

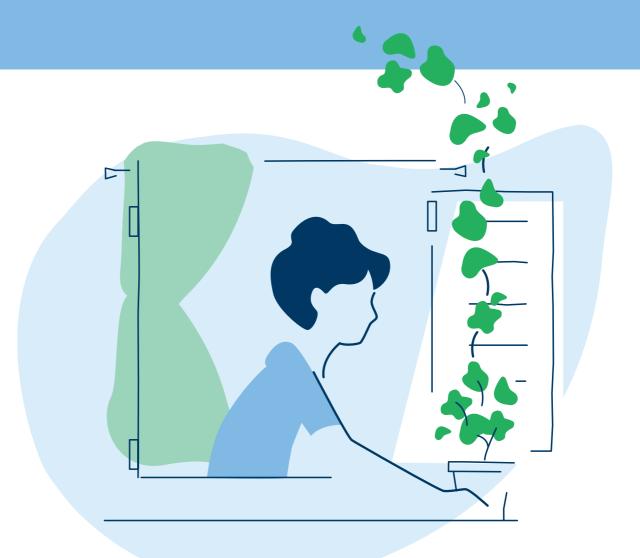
Residents of the following counties: Bedford, Cameron, Clarion, Clearfield, Elk, Huntingdon, Jefferson, Somerset, **please click here.**

Residents of Potter County, please click here.

Residents of Blair County, please click here.

Residents of Lawrence County, please click here.

Let's look at your options for a 2020 Medicare Advantage plan.



Medicare Planning Guide 2020 Covered Counties: Allegheny, Beaver, Butler, Greene, Fayette, Washington, Westmoreland





Highmark is part of a system that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

Extra perks with Highmark? For you, absolutely.

No Deductibles

Our plans start paying right away. No waiting, less worry.

Travel Benefits (PPO)

Emergency and urgent care coverage that travels with you.

Blues on CallSM

Get answers from a registered nurse or health coach, 24/7.

Vision Benefits**

Annual eye exams, lenses, and frames or contacts—all covered.

Dental Benefits**

Covered dentures, extractions, and fillings to keep you smiling.

Over-the-Counter Benefit**

Extra benefit allowance for your over-the-counter health items.

SilverSneakers®**

Stay active with no-cost exercise and wellness membership.

Transportation**

Coverage for up to 24 one-way rides for non-emergency trips.

Hearing Benefits**

Low-copays for high-quality hearing aids from TRUhearing.TM

**These come with almost all our plans. Check the benefit details to be sure.

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

step 1

step 2

plans, we'll make sure your current plan is still right for you.

Based on your health, finances, and future

If your needs change during the year, tell us. We'll review your coverage with you.

step 3

If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

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of-Network -of-Service	Community Blue Medicare HMO Signature	Community Blue Medicare HMO Prestige	Community Blue Medicare PPO Distinct	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select	Freedom Blue PPO Classic
Monthly Plan Premium ¹	\$0	\$246	\$35	\$55	\$64	\$200.50	\$267.50	\$76	\$171	\$292
Out-of-Pocket Maximum	In-Network: \$6,700	In-Network: \$6,700	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000
Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$30 Copay	PCP: \$0 Copay Specialist: \$25 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay Outpatient: \$30 Copay	Office/Lab: \$0 Copay Outpatient: \$10 Copay	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON	Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON
X-rays/Advanced Imaging	X-ray: \$30 Copay Advanced Imaging: \$250 Copay	X-ray: \$20 Copay Advanced Imaging: \$100 Copay	X-ray: \$30 Copay IN; \$40 Copay OON Advanced Imaging: \$225 Copay IN; \$325 Copay OON	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON	X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay C
Outpatient Surgery	ASC: \$225 Copay Facility: \$275 Copay	ASC: \$75 Copay Facility: \$200 Copay	ASC: \$200 Copay IN; \$325 Copay OON Facility: \$250 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON
Emergency Room/Urgent Care		Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay; Urgent Care: \$50 Copay				y; Urgent Care: \$50 Copay	
Inpatient Hospital Stay	\$295 Copay Per Admit	\$225 Copay Per Admit	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON	\$210 Copay Per Admit IN; \$210 Copay Per Admit
Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (Days 1-20			Day (Days 1-20), \$178 Per Day (Days 21-100) \$0 Per Day (Days 1-20), \$178 Per Day (Days 1-20), \$1			\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	
Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay (1 Per Year) TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year)	Exam: \$25 Copay (1 Per Year) TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). Tr Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Ye \$500 Allowance OON (Per Year)
Routine Dental	Office Visit: \$0 Copay (1 Per Six Months) X-Rays: \$0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum \$500 allowance (Per Year)	Office Visit: \$15 Copay (1 P er Six Months) X-Rays: \$15 Copay (1 Per Six Months) Comprehensive: 50% Coinsurance with a maximum \$250 allowance (per year)	 Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year) 	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Copay IN; 30% Coinsurance OON (1 Per Six Months)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (Months)
Routine Vision (Annually)	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operared eye).		eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses	 Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye). 	eyeglass lenses and frames or contact lenses are cover IN/OON: A \$150 benefit maximum applies to non- frames or a \$150 benefit maximum for specialty cont
Routine Chiropractic/ Podiatry	Chiropractic: \$20 Copay (4 Visits Per Year) Podiatry: \$30 Copay (4 Visits Per Year)	Chiropractic: \$20 Copay (8 Visits Per Year) Podiatry: \$25 Copay (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (4 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Chiropractic: \$20 Copay IN (6Visits Pear Year) Podiatry: \$30 Copay IN (8Visits Per Year)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$40 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits Per Year) Podiatry: \$30 Copay IN (10 Visits Per Year)	Chiropractic: \$20 Copay IN (10 Visits Per Year) Podiatry: \$25 Copay IN (12 Visits Per Year)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year) Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits F Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per
Formulary	Performance	Venture	Performance	Not Covered	Performance	Venture	Venture	Performance	Venture	Venture
Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33%	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	33%	5: Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33%
Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	 Preferred Retail: Preferred Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Preferred Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) 	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier Generics Tiers 3-5 (25% coinsurance) Brand (25% co including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier Generics Tiers 3-5 (25% coinsurance) Brand (25% co including 70% discount)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purc	hased through your retail pharmacy and through mail order) reach for generics and a \$8.95 Copay for all other drugs.	nes \$6,350, you pay the greater of: 5% of the cost, or \$3.60 Copay			After your yearly out-of-pocket drug costs (including dr	rugs purchased through your retail pharmacy and through mail ord	ler) reaches \$6,350, you pay the greater of: 5% of the cost, or \$3.60	0 Copay for generics and a \$8.95 Copay for all other drugs.	

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage products.

***Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

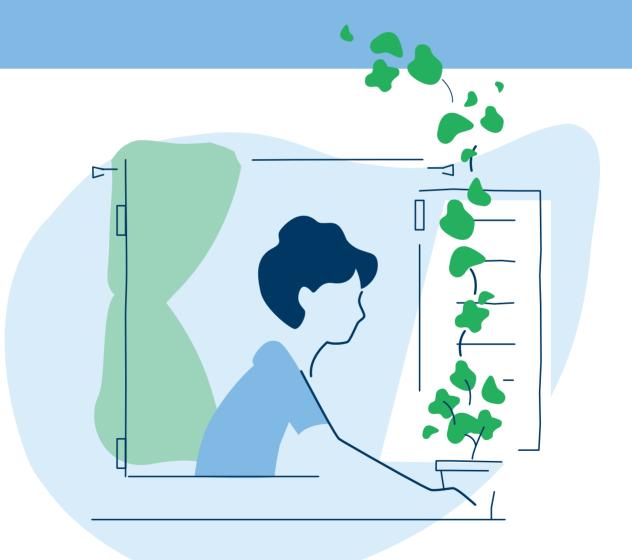
Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, Security Blue HMO-POS and/or Community Blue Medicare PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Let's look at your options for a 2020 Medicare Advantage plan.



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Monthly Plan Premium ¹	\$0	\$246	\$35	\$55	\$64	\$200.50	\$267.50	\$76	\$171	\$292	
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Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$30 Copay	PCP: \$0 Copay Specialist: \$25 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON	
Lab & Diagnostic Tests	Office/Lab: \$0 Copay Outpatient: \$30 Copay	Office/Lab: \$0 Copay Outpatient: \$10 Copay	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON	Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON	
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Outpatient Surgery	ASC: \$225 Copay Facility: \$275 Copay	ASC: \$75 Copay Facility: \$200 Copay	ASC: \$200 Copay IN; \$325 Copay OON Facility: \$250 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON	
Emergency Room/Urgent Care		Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay	y; Urgent Care: \$50 Copay		
Inpatient Hospital Stay	\$295 Copay Per Admit	\$225 Copay Per Admit	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON	\$210 Copay Per Admit IN; \$210 Copay Per Admit O	
Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)			\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)			\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		
Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay (1 Per Year) TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year)	Exam: \$25 Copay (1 Per Year) TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). Truf Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year \$500 Allowance OON (Per Year)	
Routine Dental	Office Visit: \$0 Copay (1 Per Six Months) X-Rays: \$0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum \$500 allowance (Per Year)	Office Visit: \$15 Copay (1 P er Six Months) X-Rays: \$15 Copay (1 Per Six Months) Comprehensive: 50% Coinsurance with a maximum \$250 allowance (Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-ray: \$15 Copay IN (1 Per Year)	Months)	 Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) 	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1) Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per	
Routine Vision (Annually)	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operared eye).		eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses	 Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye). 	eyeglass lenses and frames or contact lenses are covered IN/OON: A \$150 benefit maximum applies to non-sta frames or a \$150 benefit maximum for specialty contact	
Routine Chiropractic/ Podiatry	Chiropractic: \$20 Copay (4Visits Per Year) Podiatry: \$30 Copay (4Visits Per Year)	Chiropractic: \$20 Copay (8 Visits Per Year) Podiatry: \$25 Copay (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (4 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Chiropractic: \$20 Copay IN (6Visits Pear Year) Podiatry: \$30 Copay IN (8Visits Per Year)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$40 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits Per Year) Podiatry: \$30 Copay IN (10 Visits Per Year)	Chiropractic: \$20 Copay IN (10 Visits Per Year) Podiatry: \$25 Copay IN (12 Visits Per Year)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year) Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Y	
Formulary	Performance	Venture	Performance	Not Covered	Performance	Venture	Venture	Performance	Venture	Venture	
Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33%	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	33%	5: Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33%	
Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	 Preferred Retail: Preferred Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Preferred Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) 	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 Generics Tiers 3-5 (25% coinsurance) Brand (25% coins including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 Generics Tiers 3-5 (25% coinsurance) Brand (25% coins including 70% discount)	
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purc	chased through your retail pharmacy and through mail order) reach for generics and a \$8.95 Copay for all other drugs.	nes \$6,350, you pay the greater of: 5% of the cost, or \$3.60 Copay			After your yearly out-of-pocket drug costs (including dr	rugs purchased through your retail pharmacy and through mail ord	er) reaches \$6,350, you pay the greater of: 5% of the cost, or \$3.60	0 Copay for generics and a \$8.95 Copay for all other drugs.		

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage products.

***Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, Security Blue HMO-POS and/or Community Blue Medicare PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020 Covered Counties: Bedford, Cameron, Clarion, Clearfield, Elk, Huntingdon, Jefferson, Somerset

HIGHMARK.



Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

Extra perks with Highmark? For you, absolutely.

No Deductibles

Our plans start paying right away. No waiting, less worry.

Travel Benefits (PPO)

Emergency and urgent care coverage that travels with you.

Blues on CallSM

Get answers from a registered nurse or health coach, 24/7.

SilverSneakers®**

Stay active with no-cost exercise and wellness membership.

Hearing Benefits**

Low-copays for high-quality hearing aids from TRU hearing.TM

Vision Benefits**

Annual eye exams, lenses, and frames or contacts—all covered.

Dental Benefits**

Covered dentures, extractions, and fillings to keep you smiling.

Over-the-Counter Benefit**

Extra benefit allowance for your over-the-counter health items.

Transportation**

Coverage for up to 24 one-way rides for non-emergency trips.

**These come with almost all our plans. Check the benefit details to be sure.

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

step 1

step 2

Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

If your needs change during the year, tell us. We'll review your coverage with you.

step 🎯

If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

- Call **1-800-207-9304** (8 a.m.–8 p.m., seven days a week, TTY users call 711)
- Visit a Highmark Direct store or a local Medicare seminar
- Go to YourHighmarkPlan.com

DN = Out-of-Network S = Point-of-Service	Community Blue Medicare HMO Signature	Community Blue Medicare PPO Distinct	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select
Monthly Plan Premium ¹	\$0	\$35	\$58.50	\$59.50	\$166.50	\$226.50	\$73.50	\$132.50
Out-of-Pocket Maximum	In-Network: \$6,700	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000
Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$30 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay Outpatient: \$30 Copay	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON
ک م X-rays/Advanced Imaging	X-ray: \$30 Copay Advanced Imaging: \$250 Copay	X-ray: \$30 Copay IN; \$40 Copay OON Advanced Imaging: \$225 Copay IN; \$325 Copay OON	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON
Outpatient Surgery	ASC: \$225 Copay Facility: \$275 Copay	ASC: \$200 Copay IN; \$325 Copay OON Facility: \$250 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON
Emergency Room/Urgent	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$	50 Copay Emerg	gency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Cop	ay Emergency: \$9	90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay
Inpatient Hospital Stay	\$295 Copay Per Admit	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON
Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (D	Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day	y (Days 1-20), \$178 Per Day (Days 21-100)
Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay (1 Per Year) TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)
Routine Dental	Office Visit: \$0 Copay (1 Per Six Months) X-Rays: \$0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum \$500 allowance (Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/ OON (Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) Of X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)
ନ୍ଦୁ ଜି Routine Vision (Annually)	contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once	lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewea		frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear	lenses and frames or contact lenses are covered in full. IN/OON: A \$150	maximum for specialty contact lenses per year. \$200 benefit maximum
Routine Chiropractic/	per operated eye). Chiropractic: \$20 Copay (4Visits Per Year)	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$30 Copay OON (4Visits Per Year)	(once per operated eye). Chiropractic: \$20 Copay IN (6Visits PerYear)	Chiropractic: \$20 Copay IN (6 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits Per Year)	(once per operated eye). Chiropractic: \$20 Copay IN (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year)	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year)
Podiatry Formulary	Podiatry: \$30 Copay (4 Visits Per Year) Performance	Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits PerYear) Performance	Podiatry: \$30 Copay IN (8 Visits Per Year) Not Covered	Podiatry: \$40 Copay IN (8 Visits Per Year) Performance	Podiatry: \$30 Copay IN (10 Visits PerYear) Venture	Podiatry: \$25 Copay IN (12 Visits PerYear) Venture	Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits PerYear) Performance	Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year) Venture
Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%		Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% P Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% St
Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased th pay the greater of: 5% of the cost, or \$3.60 Copay	arough your retail pharmacy and through mail order) reaches \$6,350, you for generics and a \$8.95 Copay for all other drugs.	Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased th	rough your retail pharmacy and through mail order) reaches \$6,350, you Copay for all other drugs.	pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95	After your yearly out-of-pocket drug costs (including drugs purchased th	rough your retail pharmacy and through mail order) reaches \$6,350, you pay t Copay for all other drugs.

u pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

Freedom Blue PPO Classic

\$255.50

In-Network: \$4,500 | Catastrophic: \$10,000

PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON

Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON

X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay OON

ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON

\$210 Copay Per Admit IN; \$210 Copay Per Admit OON

Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)

hs) Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)

Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass 50 lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).

> Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Year)

> > Venture

Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%

Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics

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Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage products.

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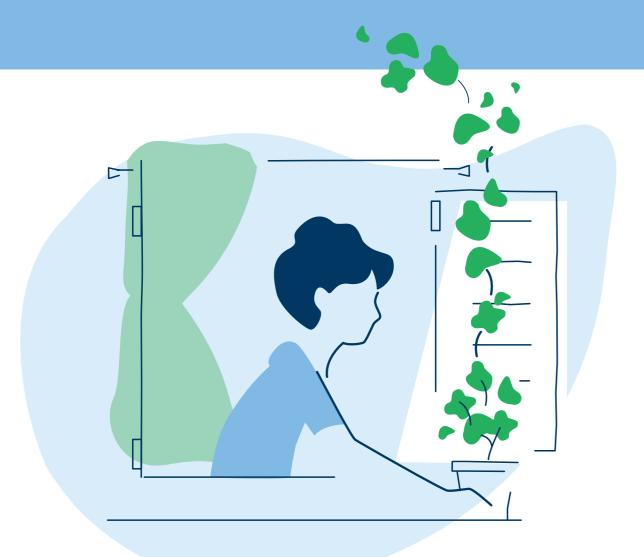
Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

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Let's look at your options for a 2020 Medicare Advantage plan.



Medicare Plan Comparison Guide 2020 Covered Counties: Crawford, Erie, Forest, McKean, Mercer, Venango, Warren





Highmark is part of a system that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

Extra perks with Highmark? For you, absolutely.

No Deductibles

Our plans start paying right away. No waiting, less worry.

Vision Benefits**

Annual eye exams, lenses, and frames or contacts—all covered.

Travel Benefits (PPO)

Emergency and urgent care coverage that travels with you.

Dental Benefits**

Covered dentures, extractions, and fillings to keep you smiling.

Blues on CallSM

Get answers from a registered nurse or health coach, 24/7.

Over-the-Counter Benefit**

Extra benefit allowance for your over-the-counter health items.

SilverSneakers®**

Stay active with no-cost exercise and wellness membership.

Transportation**

Coverage for up to 24 one-way rides for non-emergency trips.

Hearing Benefits**

Low-copays for high-quality hearing aids from TRUhearing.TM

**These come with almost all our plans. Check the benefit details to be sure.

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

you find it.

step 1

step 2

step 3

Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

If your needs change during the year, tell us. We'll review your coverage with you.

If there's a plan that fits better, we'll help

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

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ON = Out-of OS = Point-c		Community Blue Medicare HMO Signature	Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select	Freedom Blue PPO Classic
Costs	Monthly Plan Premium ¹	\$0	\$0	\$35	\$58.50	\$59.50	\$166.50	\$226.50	\$73.50	\$132.50	\$255.50
Ba Plan (Out-of-Pocket Maximum	In-Network: \$6,700	In-Network: \$5,750 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000
<u>د</u> م	Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$30 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON
nysicia ervice:	Lab & Diagnostic Tests	Office/Lab: \$0 Copay Outpatient: \$30 Copay	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON	Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON
E o	X-rays/Advanced Imaging	X-ray: \$30 Copay Advanced Imaging: \$250 Copay	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$250 Copay IN; \$300 Copay OON	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$225 Copay IN; \$325 Copay OON	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON	X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay OON
se	Outpatient Surgery	ASC: \$225 Copay Facility: \$275 Copay	ASC: \$175 Copay IN; \$350 Copay OON Facility: \$250 Copay IN; \$350 Copay OON	ASC: \$150 Copay IN; \$325 Copay OON Facility: \$225 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON
Servic	Emergency Room/Urgent Care		Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay;	; Urgent Care: \$50 Copay	
acility	Inpatient Hospital Stay	\$295 Copay Per Admit	\$275 Copay Per Admit IN; \$325 Copay Per Admit OON	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON	\$210 Copay Per Admit IN; \$210 Copay Per Admit OON
	Skilled Nursing Facility	y \$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100) \$0 Per Day (Days 1-20), \$178 Per Day (Days 1-			Days 21-100)	\$0 Per Day (Days 1-20),	20), \$178 Per Day (Days 21-100)		
	Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay (1 Per Year) TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$25 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). TruHearin Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)
tional efits	Routine Dental	Office Visit: \$0 Copay (1 Per Six Months) X-Rays: \$0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum \$500 allowance (Per Year)	 Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year) 	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-ray: \$15 Copay IN (1 Per Year)	Months)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Months)
Addi Ben	Routine Vision (Annually)	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operared eye).	and frames or contact lenses are covered in full. A \$150 benefit	- · · ·	eyeglass lenses and frames or contact lenses are covered in full.	eyeglass lenses and frames or contact lenses are covered in full IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lense
	Routine Chiropractic/ Podiatry	Chiropractic: \$20 Copay (4 Visits Per Year) Podiatry: \$30 Copay (4 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (4Visits PerYear) Podiatry: \$30 Copay IN; \$30 Copay OON (4Visits PerYear)	Chiropractic: \$20 Copay IN; \$25 Copay OON (4Visits PerYear) Podiatry: \$25 Copay IN; \$25 Copay OON (4Visits PerYear)	Chiropractic: \$20 Copay IN (6Visits PerYear) Podiatry: \$30 Copay IN (8Visits PerYear)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$40 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits PerYear) Podiatry: \$30 Copay IN (10 Visits PerYear)	Chiropractic: \$20 Copay IN (10 Visits PerYear) Podiatry: \$25 Copay IN (12 Visits PerYear)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year) Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Year)
	Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture	Performance	Venture	Venture
D Drugs 31 Days)	Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	5: 33%	 r Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% r Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% 	33%	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33%
Part (Up To	Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	 Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)
	Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs pur	chased through your retail pharmacy and through mail order) reach for generics and a \$8.95 Copay for all other drugs.	nes \$6,350, you pay the greater of: 5% of the cost, or \$3.60 Copay			After your yearly out-of-pocket drug costs (including dr	ags purchased through your retail pharmacy and through mail ord	er) reaches \$6,350, you pay the greater of: 5% of the cost, or \$3.60	Copay for generics and a \$8.95 Copay for all other drugs.	

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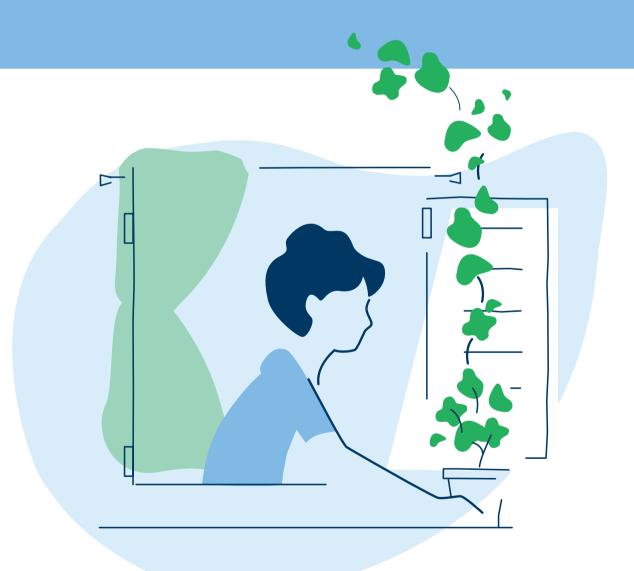
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HOW IT WORKS:

step 2

step 😚

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Out-of-Network Point-of-Service	Community Blue Medicare HMO Signature	Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select	Freedom Blue PPO Classic
Monthly Plan Premium ¹	\$0	\$0	\$35	\$55	\$64	\$200.50	\$267.50	\$76	\$171	\$292
Out-of-Pocket Maximum	In-Network: \$6,700	In-Network: \$5,750 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000
Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$30 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay Outpatient: \$30 Copay	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON	Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON
ñ X-rays/Advanced Imaging	X-ray: \$30 Copay Advanced Imaging: \$250 Copay	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$250 Copay IN; \$300 Copay OON	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$225 Copay IN; \$325 Copay OON	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON	X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay OON
Outpatient Surgery	ASC: \$225 Copay Facility: \$275 Copay	ASC: \$175 Copay IN; \$350 Copay OON Facility: \$250 Copay IN; \$350 Copay OON	ASC: \$150 Copay IN; \$325 Copay OON Facility: \$225 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON
Emergency Room/Urgent Care		Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay; Urgent Care: \$50 Copay			Emergency: \$90 Copay	y; Urgent Care: \$50 Copay	
Inpatient Hospital Stay	\$295 Copay Per Admit	\$275 Copay Per Admit IN; \$325 Copay Per Admit OON	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON	\$210 Copay Per Admit IN; \$210 Copay Per Admit OON
Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	1-20), \$178 Per Day (Days 21-100) \$0 Per Day (Days 1-20), \$178 Per Day		Days 21-100) \$0 Per Day (Days 1		1-20), \$178 Per Day (Days 21-100)		
Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay (1 Per Year) TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$25 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)
Routine Dental	Office Visit: \$0 Copay (1 Per Six Months) X-Rays: \$0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum \$500 allowance (Per Year)	 Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year) 		Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)		Consurance OON (1 Per Six Months)	
Routine Vision (Annually)	Exam: \$0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operared eye).		eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses	 Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses e per year. \$200 benefit maximum for post cataract eyewear (once per operated eye). 	eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses
Routine Chiropractic/ Podiatry	Chiropractic: \$20 Copay (4 Visits Per Year) Podiatry: \$30 Copay (4 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (4 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (4 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (4 Visits Per Year)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$30 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$40 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits Per Year) Podiatry: \$30 Copay IN (10 Visits Per Year)	Chiropractic: \$20 Copay IN (10 Visits Per Year) Podiatry: \$25 Copay IN (12 Visits Per Year)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year) Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Year)
Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture	Performance	Venture	Venture
Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail:Tier 1: \$0,Tier 2: \$5,Tier 3: \$47,Tier 4: \$100,Tier 5 33% Standard Retail:Tier 1: \$7,Tier 2: \$15,Tier 3: \$47,Tier 4: \$100,Tier 5: 33%	33%	Preferred Retail: Tier 1: \$0, Tier 2: \$9, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	33%	 Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% 	33%
Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	 Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs pu	rchased through your retail pharmacy and through mail order) reach for generics and a \$8.95 Copay for all other drugs.	nes \$6,350, you pay the greater of: 5% of the cost, or \$3.60 Copay			After your yearly out-of-pocket drug costs (including dr	ugs purchased through your retail pharmacy and through mail orde	er) reaches \$6,350, you pay the greater of: 5% of the cost, or \$3.60) Copay for generics and a \$8.95 Copay for all other drugs.	

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage Products.

***Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

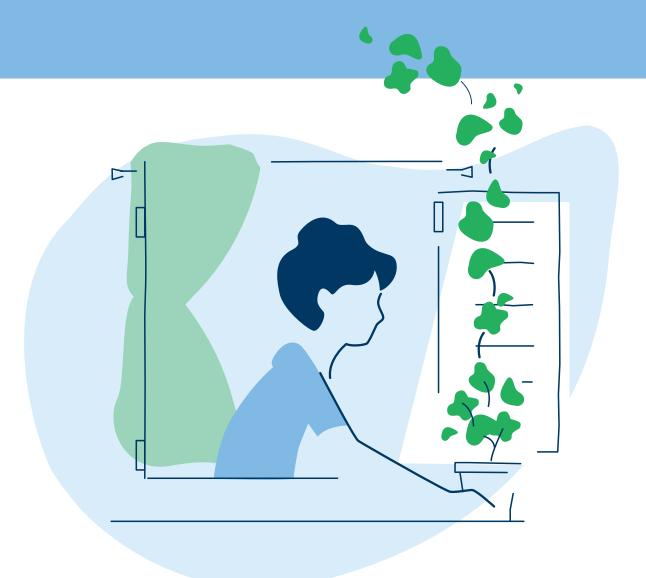
Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, Security Blue HMO-POS and/or Community Blue Medicare PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Let's look at your options for a 2020 Medicare Advantage plan.



Medicare Plan Comparison Guide 2020 Covered Counties: Potter





Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

Extra perks with Highmark? For you, absolutely.

No Deductibles

Our plans start paying right away. No waiting, less worry.

Travel Benefits (PPO)

Emergency and urgent care coverage that travels with you.

Blues on CallSM

Get answers from a registered nurse or health coach, 24/7.

SilverSneakers®**

Stay active with no-cost exercise and wellness membership.

Hearing Benefits**

Low-copays for high-quality hearing aids from TRUhearing.TM

Vision Benefits**

Annual eye exams, lenses, and frames or contacts—all covered.

Dental Benefits**

Covered dentures, extractions, and fillings to keep you smiling.

Over-the-Counter Benefit**

Extra benefit allowance for your over-the-counter health items.

Transportation**

Coverage for up to 24 one-way rides for non-emergency trips.

**These come with almost all our plans. Check the benefit details to be sure.

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.



step 2

step 🔏

HOW IT WORKS:

Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

If your needs change during the year, tell us. We'll review your coverage with you.

If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

- Call **1-800-207-9304** (8 a.m.–8 p.m., seven days a week, TTY users call 711)
- Visit a Highmark Direct store or a local Medicare seminar
- Go to YourHighmarkPlan.com

t-of-Network nt-of-Service	Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select
Monthly Plan Premium ¹	\$0	\$35	\$58.50	\$59.50	\$186.50	\$226.50	\$73.50	\$132.50
Out-of-Pocket Maximum	In-Network: \$5,750 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000
Doctor Office Per Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$35 Copay OON Outpatient: \$25 Copay IN; \$35 Copay OON	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON
X-rays/Advanced Imaging	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$250 Copay IN; \$300 Copay OON	X-ray: \$20 Copay IN; \$35 Copay OON Advanced Imaging: \$225 Copay IN; \$325 Copay OON	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON
Outpatient Surgery	ASC: \$175 Copay IN; \$350 Copay OON Facility: \$250 Copay IN; \$350 Copay OON	ASC: \$150 Copay IN; \$325 Copay OON Facility: \$225 Copay IN; \$325 Copay OON	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON
Emergency Room/Urgent Care	Emergency: \$90 Copay; Urgent	Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$5	50 Copay Emerg	ency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay	y Emergency: \$90 C
Inpatient Hospital Stay	\$275 Copay Per Admit IN; \$325 Copay Per Admit OON	\$275 Copay Per Admit IN; \$350 Copay Per Admit OON	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON
Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (Da	ays 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day	y (Days 1-20), \$178 Per Day (Days 21-100)
Routine Hearing (2 Hearing Aids per year)	Exam: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$25 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)
Routine Dental	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/ OON (Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/ OON (Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)
Routine Vision (Annually)	lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum	benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewea	frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear	lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum
Routine Chiropractic/	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$30 Copay OON (4 Visits Per Year)	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$25 Copay OON (4 Visits Per Year)	(once per operated eye). Chiropractic: \$20 Copay IN (6 Visits Per Year)	(once per operated eye). Chiropractic: \$20 Copay IN (6Visits Per Year)	(once per operared eye). Chiropractic: \$20 Copay IN (8 Visits Per Year)	(once per operated eye). Chiropractic: \$20 Copay IN (10 Visits Per Year)	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year)	for post cataract eyewear (once per operated eye). Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year)
Podiatry	Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Podiatry: \$25 Copay IN; \$25 Copay OON (4 Visits Per Year)	Podiatry: \$30 Copay IN (8 Visits Per Year)	Podiatry: \$40 Copay IN (8 Visits Per Year)	Podiatry: \$30 Copay IN (10 Visits Per Year)	Podiatry: \$25 Copay IN (12 Visits Per Year)	Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)
Formulary Initial Coverage- Up to	Performance	Performance	Not Covered	Performance	Venture	Venture	Performance	Venture
\$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%		Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)
								rough your retail pharmacy and through mail order) reaches \$6,350, you pay

u pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

Freedom Blue PPO Classic

\$255.50

In-Network: \$4,500 | Catastrophic: \$10,000

PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON

Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON

X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay OON

ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON

90 Copay; Urgent Care: \$50 Copay

\$210 Copay Per Admit IN; \$210 Copay Per Admit OON

Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)

s) Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)

Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).

Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Year)

Venture

Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%

Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics

Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)

***Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

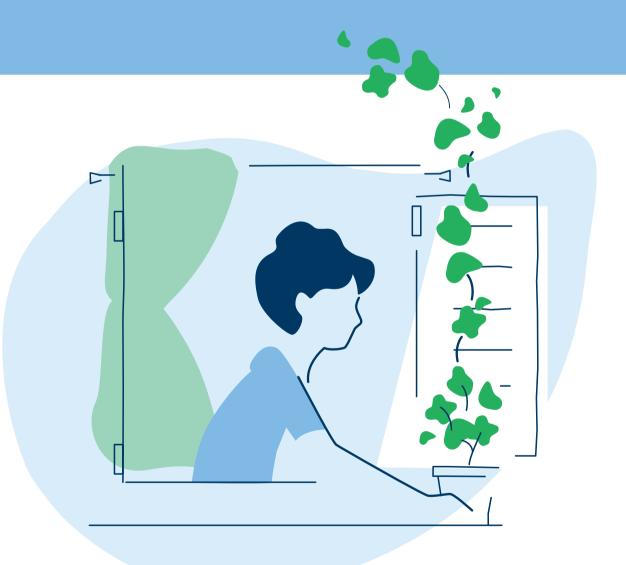
Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, Security Blue HMO-POS and/or Community Blue Medicare PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Let's look at your options for a 2020 Medicare Advantage plan.



Medicare Plan Comparison Guide 2020 Covered Counties: Blair





Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

step 1

HOW IT WORKS:

Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

If your needs change during the year, tell us. We'll review your coverage with you.

step 🎯

step 2

If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

- Call **1-800-207-9304** (8 a.m.–8 p.m., seven days a week, TTY users call 711)
- Visit a Highmark Direct store or a local Medicare seminar
- Go to YourHighmarkPlan.com

	-of-Network t-of-Service	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe	Freedom Blue PPO ValueRx	Freedom Blue PPO Select	Freedom Blue PPO Classic
sic	Monthly Plan Premium ¹	\$58.50	\$59.50	\$186.50	\$226.50	\$73.50	\$132.50	\$255.50
Ba; Plan (Out-of-Pocket Maximum	In-Network: \$5,900 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000	In-Network: \$5,500 Catastrophic: \$10,000	In-Network: \$5,000 Catastrophic: \$10,000	In-Network: \$4,500 Catastrophic: \$10,000
5	Doctor Office Per Visit	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$40 Copay IN; \$40 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$30 Copay IN; \$30 Copay POS	PCP: \$0 Copay IN; \$0 Copay POS Specialist: \$25 Copay IN; \$25 Copay POS	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$40 Copay IN; \$40 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON
ıysiciaı ervices	Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN; \$30 Copay POS Outpatient: \$20 Copay IN; \$30 Copay POS	Office/Lab: \$0 Copay IN; \$25 Copay POS Outpatient: \$20 Copay IN; \$25 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$15 Copay POS Outpatient: \$10 Copay IN; \$15 Copay POS	Office/Lab: \$0 Copay IN; \$20 Copay OON Outpatient: \$20 Copay IN; \$20 Copay OON	Office/Lab: \$0 Copay IN; \$15 Copay OON Outpatient: \$15 Copay IN; \$15 Copay OON	Office/Lab: \$0 Copay IN; \$10 Copay OON Outpatient: \$10 Copay IN; \$10 Copay OON
년 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	X-rays/Advanced Imaging	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$100 Copay IN; \$175 Copay POS	X-ray: \$25 Copay IN; \$40 Copay POS Advanced Imaging: \$200 Copay IN; \$250 Copay POS	X-ray: \$20 Copay IN; \$35 Copay POS Advanced Imaging: \$150 Copay IN; \$200 Copay POS	X-ray: \$15 Copay IN; \$30 Copay POS Advanced Imaging: \$100 Copay IN; \$150 Copay POS	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$200 Copay IN; \$200 Copay OON	X-ray: \$25 Copay IN; \$25 Copay OON Advanced Imaging: \$150 Copay IN; \$150 Copay OON	X-ray: \$15 Copay IN; \$15 Copay OON Advanced Imaging: \$125 Copay IN; \$125 Copay OON
ω	Outpatient Surgery	ASC: \$100 Copay IN; \$250 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS Facility: \$250 Copay IN; \$300 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS Facility: \$225 Copay IN; \$275 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS Facility: \$200 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$250 Copay OON Facility: \$250 Copay IN; \$250 Copay OON	ASC: \$125 Copay IN; \$225 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$75 Copay IN; \$200 Copay OON Facility: \$200 Copay IN; \$200 Copay OON
ervice.	Emergency Room/Urgent Care	Emergency: \$90 Copay; Urgent Care: \$50 Copay		Emergency: \$	90 Copay; Urgent Care: \$50 Copay		Em	ergency: \$90 Copay; Urgent Care: \$50 Copay
<mark>lealt</mark> cility s	Inpatient Hospital Stay	\$340 Copay Per Admit IN; \$390 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day Copay (days 6-90) IN; \$270/day Copay (days 1-5), \$0/day Copay (days 6-90) POS	\$335 Copay Per Admit IN; \$385 Copay Per Admit POS	\$210 Copay Per Admit IN; \$260 Copay Per Admit POS	\$220/day Copay (days 1-5), \$0/day (days 6-90) IN; \$220/day Copay (days 1-5), \$0/day (days 6-90) OON	\$350 Copay Per Admit IN; \$350 Copay Per Admit OON	\$210 Copay Per Admit IN; \$210 Copay Per Admit OON
	Skilled Nursing Facility	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 P	er Day (Days 1-20), \$178 Per Day (Days 21-100)		\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	
	Routine Hearing (2 Hearing Aids per year)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN (1 Per Year). TruHearing Advanced: \$499 Copay; TruHearing Premium: \$799 Copay (2 Aids Every Year IN)	Exam: \$0 Copay IN; \$40 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)	Exam: \$0 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Enhanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance OON (Per Year)
its a	Routine Dental	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN (1 Per Six Months) X-Rays: \$15 Copay IN (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months) X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year)
Additio Benefi	Routine Vision (Annually)	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN (1 Per Year). IN: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operared eye).		benefit maximum applies to non-standard frames or a \$150 benefit	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).
	Routine Chiropractic/ Podiatry	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$30 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (6 Visits Per Year) Podiatry: \$40 Copay IN (8 Visits Per Year)	Chiropractic: \$20 Copay IN (8 Visits Per Year) Podiatry: \$30 Copay IN (10 Visits Per Year)	Chiropractic: \$20 Copay IN (10 Visits Per Year) Podiatry: \$25 Copay IN (12 Visits Per Year)	Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year) Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Chiropractic: \$20 Copay IN; \$30 Copay OON (8 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (10 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (10 Visits Per Year) Podiatry: \$25 Copay IN; \$25 Copay OON (12 Visits Per Year)
	Formulary	Not Covered	Performance	Venture	Venture	Performance	Venture	Venture
rug D Drugs 31 Days)	Initial Coverage- Up to \$4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
D Part I (Up To	Coverage Gap	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	 Preferred Retail: Generics: Tier 1 (\$0) Generics: Tier 2 (\$13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)
	Catastrophic Coverage	Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased thr	ough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	bay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95	After your yearly out-of-pocket drug costs (including drugs purchased the	rough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	bay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

**Does not apply to all benefits across all plans.

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage products.

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