2021 Security Blue Medicare HMO-POS Summary of Benefits

Residents of the following counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland, **please click here.**

Residents of the following counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Somerset, Venango and Warren, **please click here.**

Residents of the following counties: Potter, **please click here.**

HIGHMARK

Security Blue HMO-POS

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Potter

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Security Blue HMO-POS, call 1-866-670-5844 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Security Blue HMO-POS has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Point-Of-Service Benefit

The Point-Of-Service (POS) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

	Security Blue HMO-POS Deluxe	Security Blue HMO-POS Basic
Premium	$225	$57
Deductible	$0	$0
Max Out-Of-Pocket	$4,500 IN; $10,000 Catastrophic	$5,900 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$210 Copay Per Admit IN; $260 Copay Per Admit POS	$340 Copay Per Admit IN; $390 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay POS Specialist: $25 Copay IN; $25 Copay POS	PCP: $0 Copay IN; $0 Copay POS Specialist: $30 Copay IN; $30 Copay POS
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	Office/Lab: $0 Copay IN; $15 Copay POS Outpatient: $10 Copay IN; $15 Copay POS	Office/Lab: $0 Copay IN; $30 Copay POS Outpatient: $20 Copay IN; $30 Copay POS
X-Rays*/ Advanced Imaging*	X-ray: $15 Copay IN; $30 Copay POS Advanced Imaging: $100 Copay IN; $150 Copay POS	X-ray: $25 Copay IN; $40 Copay POS Advanced Imaging: $100 Copay IN; $175 Copay POS
Hearing Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $25 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$25 Copay IN; $30 Copay POS	$30 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $160 Copay IN	Emergent/Non-Emergent: $125 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$25 Copay IN (12 Visits Per Year)	$30 Copay IN (8 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Venture	Not Offered

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Standard
Premium	$58	$185
Deductible	$0	$0
Max Out-Of-Pocket	$5,500 IN; $10,000 Catastrophic	$5,000 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS	$335 Copay Per Admit IN; $385 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS	ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS
Doctor Office Visit	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
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	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
X-Rays*/ Advanced Imaging*	X-ray: $20 Copay IN; $25 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
Hearing Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS Outpatient: $40 Copay IN; $45 Copay POS	Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$40 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $285 Copay IN	Emergent/Non-Emergent: $210 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$40 Copay IN (8 Visits Per Year)	$30 Copay IN (10 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Performance	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Security Blue HMO-POS Deluxe

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$105 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table Below

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$15 Copay
Tier 2 (Generic)	Not Applicable	$57 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Standard

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$44 Copay	$132 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$110 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Deluxe Coverage Gap Table

Coverage Gap	Standard Network	Tier	
		Tier 1 (Preferred Generic)	$0 Copay
		Tier 2 (Generic)	$13 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	N/A
		Tier 2 (Generic)	N/A
		Tier 3-5 (Generic)	N/A
		Brand	N/A

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Choice Company. Highmark Blue Cross Blue Shield provides post-sale administrative communications for these companies.
Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.
Out-of-network/non-contracted providers are under no obligation to treat Security Blue HMO-POS 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.

This information is not a complete description of benefits. Call 1-866-670-5844 (TTY users may call 711) for more nformation.

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

HIGHMARK

WEST CENTRAL PENNSYLVANIA

Security Blue HMO-POS

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Somerset, Venango and Warren

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Security Blue HMO-POS, call 1-866-670-5844 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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West Central Pennsylvania

This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Security Blue HMO-POS has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Point-Of-Service Benefit

The Point-Of-Service (POS) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

West Central Pennsylvania

	Security Blue HMO-POS Deluxe	Security Blue HMO-POS Standard
Premium	$225	$165
Deductible	$0	$0
Max Out-Of-Pocket	$4,500 IN; $10,000 Catastrophic	$5,000 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$210 Copay Per Admit IN; $260 Copay Per Admit POS	$335 Copay Per Admit IN; $385 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay POS Specialist: $25 Copay IN; $25 Copay POS	PCP: $0 Copay IN; $0 Copay POS Specialist: $30 Copay IN; $30 Copay POS
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	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
X-Rays*/ Advanced Imaging*	X-ray: $15 Copay IN; $30 Copay POS Advanced Imaging: $100 Copay IN; $150 Copay POS	X-ray: $20 Copay IN; $35 Copay POS Advanced Imaging: $150 Copay IN; $200 Copay POS
Hearing Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $25 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS	Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$25 Copay IN; $30 Copay POS	$30 Copay IN; $35 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $160 Copay IN	Emergent/Non-Emergent: $210 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$25 Copay IN (12 Visits Per Year)	$30 Copay IN (10 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Venture	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Basic
Premium	$58	$57
Deductible	$0	$0
Max Out-Of-Pocket	$5,500 IN; $10,000 Catastrophic	$5,900 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS	$340 Copay Per Admit IN; $390 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS
Doctor Office Visit	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
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	Office/Lab: $0 Copay IN; $25 Copay POS Outpatient: $20 Copay IN; $25 Copay POS	Office/Lab: $0 Copay IN; $30 Copay POS Outpatient: $20 Copay IN; $30 Copay POS
X-Rays*/ Advanced Imaging*	X-ray: $20 Copay IN; $25 Copay POS Advanced Imaging: $200 Copay IN; $250 Copay POS	X-ray: $25 Copay IN; $40 Copay POS Advanced Imaging: $100 Copay IN; $175 Copay POS
Hearing Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS Outpatient: $40 Copay IN; $45 Copay POS	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$40 Copay IN; $45 Copay POS	$30 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $285 Copay IN	Emergent/Non-Emergent: $125 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$40 Copay IN (8 Visits Per Year)	$30 Copay IN (8 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Performance	Not Offered

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Security Blue HMO-POS Deluxe

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$105 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table Below

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Standard

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$44 Copay	$132 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$110 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$15 Copay
Tier 2 (Generic)	Not Applicable	$57 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Deluxe Coverage Gap Table

Coverage Gap	Standard Network	Tier	
		Tier 1 (Preferred Generic)	$0 Copay
		Tier 2 (Generic)	$13 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	N/A
		Tier 2 (Generic)	N/A
		Tier 3-5 (Generic)	N/A
		Brand	N/A

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Choice Company. Highmark Blue Cross Blue Shield provides post-sale administrative communications for these companies.
Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.
Out-of-network/non-contracted providers are under no obligation to treat Security Blue HMO-POS 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.

This information is not a complete description of benefits. Call 1-866-670-5844 (TTY users may call 711) for more information.

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

HIGHMARK

SOUTHWESTERN PENNSYLVANIA

Security Blue HMO-POS

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Security Blue HMO-POS, call 1-866-670-5844 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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Southwestern Pennsylvania

This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Security Blue HMO-POS has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Point-Of-Service Benefit

The Point-Of-Service (POS) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

Southwestern Pennsylvania

	Security Blue HMO-POS Deluxe	Security Blue HMO-POS Standard
Premium	$266	$199
Deductible	$0	$0
Max Out-Of-Pocket	$4,500 IN; $10,000 Catastrophic	$5,000 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$210 Copay Per Admit IN; $260 Copay Per Admit POS	$335 Copay Per Admit IN; $385 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS
Doctor Office Visit	PCP: $0 Copay IN; $0 Copay POS Specialist: $25 Copay IN; $25 Copay POS	PCP: $0 Copay IN; $0 Copay POS Specialist: $30 Copay IN; $30 Copay POS
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	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
X-Rays*/ Advanced Imaging*	X-ray: $15 Copay IN; $30 Copay POS Advanced Imaging: $100 Copay IN; $150 Copay POS	X-ray: $20 Copay IN; $35 Copay POS Advanced Imaging: $150 Copay IN; $200 Copay POS
Hearing Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $25 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $25 Copay IN; $25 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS	Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$25 Copay IN; $30 Copay POS	$30 Copay IN; $35 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $160 Copay IN	Emergent/Non-Emergent: $210 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$25 Copay IN (12 Visits Per Year)	$30 Copay IN (10 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Venture	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

	Security Blue HMO-POS ValueRx	Security Blue HMO-POS Basic
Premium	$63	$54
Deductible	$0	$0
Max Out-Of-Pocket	$5,500 IN; $10,000 Catastrophic	$5,900 IN; $10,000 Catastrophic
Inpatient Hospital Stay*	$220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS	$340 Copay Per Admit IN; $390 Copay Per Admit POS
Outpatient Hospital Coverage*	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS
Doctor Office Visit	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
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/POS	Covered in Full (Office visit Copay may apply) IN/POS
Emergency Room	$90 Copay IN/POS	$90 Copay IN/POS
Urgently Needed Services	$50 Copay IN/POS	$50 Copay IN/POS
Lab & Diagnostic Tests*	Office/Lab: $0 Copay IN; $25 Copay POS Outpatient: $20 Copay IN; $25 Copay POS	Office/Lab: $0 Copay IN; $30 Copay POS Outpatient: $20 Copay IN; $30 Copay POS
X-Rays*/ Advanced Imaging*	X-ray: $20 Copay IN; $25 Copay POS Advanced Imaging: $200 Copay IN; $250 Copay POS	X-ray: $25 Copay IN; $40 Copay POS Advanced Imaging: $100 Copay IN; $175 Copay POS
Hearing Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $0 Copay IN (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN)
Dental Services	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	Medicare Covered: $40 Copay IN; $40 Copay POS. Routine: $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).	Medicare Covered: $30 Copay IN; $30 Copay POS. Routine: $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).
Mental Health Services*	Inpatient: $220 Copay/day (days 1-5), $0 Copay/day (days 6-90) IN; $270 Copay/day (days 1-5), $0 Copay/day (days 6-90) POS Outpatient: $40 Copay IN; $45 Copay POS	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN	$0 Copay/day (days 1-20), $184 Copay/day (days 21-100) IN
Physical Therapy*	$40 Copay IN; $45 Copay POS	$30 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $275 Copay IN	Emergent/Non-Emergent: $125 Copay IN
Transportation (up-to 24 one-way trips)*	$10 Copay IN	$10 Copay IN
Part B Drugs*	20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
Routine Podiatry	$40 Copay IN (8 Visits Per Year)	$30 Copay IN (8 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance IN	20% Coinsurance IN
Fitness Benefit	Covered in Full IN	Covered in Full IN
Formulary	Performance	Not Offered

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Security Blue HMO-POS Deluxe

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$105 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table Below

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Standard

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$44 Copay	$132 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$32.50 Copay
Tier 3 (Preferred Brand)	Not Applicable	$110 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$250 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,550, you pay the greater of: 5% of the cost, or $3.70 Copay for generics and a $9.20 Copay for all other drugs.

Greater of: 5% or $3.70 Generic / Preferred Multi-Source or $9.20 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,130.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$15 Copay
Tier 2 (Generic)	Not Applicable	$57 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

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Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

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If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Security Blue HMO-POS Deluxe Coverage Gap Table

Coverage Gap	Standard Network	Tier	
		Tier 1 (Preferred Generic)	$0 Copay
		Tier 2 (Generic)	$13 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	N/A
		Tier 2 (Generic)	N/A
		Tier 3-5 (Generic)	N/A
		Brand	N/A

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Choice Company. Highmark Blue Cross Blue Shield provides post-sale administrative communications for these companies.
Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.
Out-of-network/non-contracted providers are under no obligation to treat Security Blue HMO-POS 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.

This information is not a complete description of benefits. Call 1-866-670-5844 (TTY users may call 711) for more nformation.

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TruHearing is a registered trademark of TruHearing, Inc.