2020 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, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Somerset, Venango and Warren, **please click here.**

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

HIGHMARK

SOUTHWESTERN PENNSYLVANIA

Security Blue HMO-POS

Summary of Benefits

January 1, 2020 to December 31, 2020

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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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

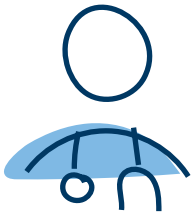
The Point-Of-Service (POS) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

Blues On Call℠

Answers from a health pro, 24/7.

Travel Benefits (PPO)

Coverage that travels with you.



Telemedicine

Face-to-face with a doctor, 24/7.

Highmark House Call

Once-a-year in-home health review.

If you have questions as you go along, visit medicare.highmark.com.

Southwestern Pennsylvania

	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx
Premium	$55	$64
Deductible	$0	$0
Max Out-Of-Pocket	$5,900 IN; $10,000 Catastrophic	$5,500 IN; $10,000 Catastrophic
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
Outpatient Hospital Coverage*	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS
Doctor Office 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
Preventive/ Screening	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; $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
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
Hearing Services	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)	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)
Dental Services	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	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).	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).
Mental Health Services*	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS	Inpatient: $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 Outpatient: $40 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
Physical Therapy*	$30 Copay IN; $45 Copay POS	$40 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $125 Copay IN	Emergent/Non-Emergent: $225 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	$30 Copay IN (8 Visits Per Year)	$40 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	Not Covered	Performance

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe
$200.50	$267.50
$0	$0
$5,000 IN; $10,000 Catastrophic	$4,500 IN; $10,000 Catastrophic
$335 Copay Per Admit IN; $385 Copay Per Admit POS	$210 Copay Per Admit IN; $260 Copay Per Admit POS
ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 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
Covered in Full (Office visit Copay may apply) IN/OON	
$90 Copay IN/POS	$90 Copay IN/POS
$50 Copay IN/POS	$50 Copay IN/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
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
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)	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 Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	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; $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 operared eye).	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).
Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS
$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Emergent/Non-Emergent: $175 Copay IN	Emergent/Non-Emergent: $125 Copay IN
$10 Copay IN	$10 Copay IN
20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
$30 Copay IN (10 Visits Per Year)	$25 Copay IN (12 Visits Per Year)
20% Coinsurance IN	20% Coinsurance IN
Covered in Full IN	Covered in Full IN
Venture	Venture

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

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 Offered

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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 $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

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See Table on Next Page

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) 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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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)	Not Offered
		Tier 2 (Generic)	Not Offered
		Tiers 3-5 (Generic)	Not Offered
		Brand	Not Offered

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. 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 the phone number on the back of your member ID card (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®

WEST CENTRAL PENNSYLVANIA

Security Blue HMO-POS

Summary of Benefits

January 1, 2020 to December 31, 2020

The service area for these plans includes the following counties:

Bedford, 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.

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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

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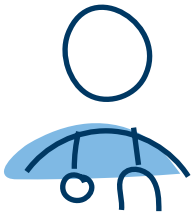
Travel Benefits (PPO)

Coverage that travels with you.



Telemedicine

Face-to-face with a doctor, 24/7.

Highmark House Call

Once-a-year in-home health review.

If you have questions as you go along, visit medicare.highmark.com.

West Central Pennsylvania

	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx
Premium	$58.50	$59.50
Deductible	$0	$0
Max Out-Of-Pocket	$5,900 IN; $10,000 Catastrophic	$5,500 IN; $10,000 Catastrophic
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
Outpatient Hospital Coverage*	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS
Doctor Office 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
Preventive/ Screening	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; $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
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
Hearing Services	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)	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)
Dental Services	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	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).	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).
Mental Health Services*	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS	Inpatient: $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 Outpatient: $40 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
Physical Therapy*	$30 Copay IN; $45 Copay POS	$40 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $125 Copay IN	Emergent/Non-Emergent: $225 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	$30 Copay IN (8 Visits Per Year)	$40 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	Not Covered	Performance

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe
$166.50	$226.50
$0	$0
$5,000 IN; $10,000 Catastrophic	$4,500 IN; $10,000 Catastrophic
$335 Copay Per Admit IN; $385 Copay Per Admit POS	$210 Copay Per Admit IN; $260 Copay Per Admit POS
ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 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
Covered in Full (Office visit Copay may apply) IN/POS	
$90 Copay IN/POS	$90 Copay IN/POS
$50 Copay IN/POS	$50 Copay IN/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
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
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)	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 Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	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; $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).	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).
Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS
$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Emergent/Non-Emergent: $175 Copay IN	Emergent/Non-Emergent: $125 Copay IN
$10 Copay IN	$10 Copay IN
20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
$30 Copay IN (10 Visits Per Year)	$25 Copay IN (12 Visits Per Year)
20% Coinsurance IN	20% Coinsurance IN
Covered in Full IN	Covered in Full IN
Venture	Venture

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

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 Offered

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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 $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table on Next Page

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) 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.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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)	Not Offered
		Tier 2 (Generic)	Not Offered
		Tiers 3-5 (Generic)	Not Offered
		Brand	Not Offered

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. 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 the phone number on the back of your member ID card (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

BLAIR/POTTER

Security Blue HMO-POS

Summary of Benefits

January 1, 2020 to December 31, 2020

The service area for these plans includes the following counties:

Blair and 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

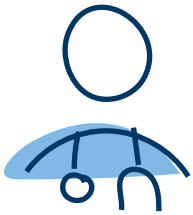
The Point-Of-Service (POS) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

Blues On Call℠

Answers from a health pro, 24/7.

Travel Benefits (PPO)

Coverage that travels with you.



Telemedicine

Face-to-face with a doctor, 24/7.

Highmark House Call

Once-a-year in-home health review.

If you have questions as you go along, visit medicare.highmark.com.

Blair/Potter

	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx
Premium	$58.50	$59.50
Deductible	$0	$0
Max Out-Of-Pocket	$5,900 IN; $10,000 Catastrophic	$5,500 IN; $10,000 Catastrophic
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
Outpatient Hospital Coverage*	ASC[1]: $100 Copay IN; $250 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC[1]: $175 Copay IN; $225 Copay POS Facility: $250 Copay IN; $300 Copay POS
Doctor Office 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
Preventive/ Screening	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; $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
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
Hearing Services	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)	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)
Dental Services	Medicare Covered: $30 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	Medicare Covered: $40 Copay IN Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)
Vision Services	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).	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).
Mental Health Services*	Inpatient: $340 Copay Per Admit IN; $390 Copay Per Admit POS Outpatient: $30 Copay IN; $45 Copay POS	Inpatient: $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 Outpatient: $40 Copay IN; $45 Copay POS
Skilled Nursing Facility*	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
Physical Therapy*	$30 Copay IN; $45 Copay POS	$40 Copay IN; $45 Copay POS
Ambulance** (per one-way trip)	Emergent/Non-Emergent: $125 Copay IN	Emergent/Non-Emergent: $225 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	$30 Copay IN (8 Visits Per Year)	$40 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	Not Covered	Performance

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe
$186.50	$226.50
$0	$0
$5,000 IN; $10,000 Catastrophic	$4,500 IN; $10,000 Catastrophic
$335 Copay Per Admit IN; $385 Copay Per Admit POS	$210 Copay Per Admit IN; $260 Copay Per Admit POS
ASC[1]: $125 Copay IN; $175 Copay POS Facility: $225 Copay IN; $275 Copay POS	ASC[1]: $75 Copay IN; $125 Copay POS Facility: $200 Copay IN; $250 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
Covered in Full (Office visit Copay may apply) IN/POS	
$90 Copay IN/POS	$90 Copay IN/POS
$50 Copay IN/POS	$50 Copay IN/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
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
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)	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 Office Visit: $15 Copay IN (1 Per Six Months) X-Rays: $15 Copay IN (1 Per Year)	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; $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 operared eye).	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).
Inpatient: $335 Copay Per Admit IN; $385 Copay Per Admit POS Outpatient: $30 Copay IN; $35 Copay POS	Inpatient: $210 Copay Per Admit IN; $260 Copay Per Admit POS Outpatient: $25 Copay IN; $30 Copay POS
$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN	$0/day Copay (days 1-20); $178/day Copay (days 21-100) IN
$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Emergent/Non-Emergent: $175 Copay IN	Emergent/Non-Emergent: $125 Copay IN
$10 Copay IN	$10 Copay IN
20% Coinsurance IN; 30% Coinsurance POS	20% Coinsurance IN; 30% Coinsurance POS
$30 Copay IN (10 Visits Per Year)	$25 Copay IN (12 Visits Per Year)
20% Coinsurance IN	20% Coinsurance IN
Covered in Full IN	Covered in Full IN
Venture	Venture

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

[1]ASC=Ambulatory Surgery Center

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

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 Offered

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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 $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, 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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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

DRUG

You pay the following until your total yearly drug costs reach $4,020.
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 Offered

Standard Mail Cost-Sharing

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

Preferred Retail Cost-Sharing

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

Preferred Mail Cost-Sharing

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

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table on Next Page

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) 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.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 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)	Not Offered
		Tier 2 (Generic)	Not Offered
		Tiers 3-5 (Generic)	Not Offered
		Brand	Not Offered

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. 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 the phone number on the back of your member ID card (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.