HIGHMARK

WEST CENTRAL PENNSYLVANIA

Security Blue HMO-POS

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, 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."

	Security Blue HMO-POS Basic	Security Blue HMO-POS ValueRx
Premium	$49.00	$54.00
Part B Premium Reduction	$0.00	$0.00
Deductible	$0	$0
Max Out-Of-Pocket	$5,900 IN; $8,950 Catastrophic	$5,500 IN; $8,950 Catastrophic
Inpatient Hospital Stay*	$340 copay per admit IN; $390 copay per admit POS	Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit IN; Days 1 - 5: $270 copay per day per admit & Days 6 - 90: $0 copay per admit 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: $200 copay IN; $250 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	Covered in Full (Office visit copay may apply) IN/POS
Emergency Room	$95 copay IN/POS	$95 copay IN/POS
Urgently Needed Services	$50 copay IN/POS	$5 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: $20 copay IN; $25 copay POS Advanced Imaging: $175 copay IN; $225 copay POS
Hearing Services	Medicare Covered: $30 copay IN; $30 copay POS. Routine: $0 copay IN (1 Per Year). (2 Aids Every Year IN) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay	Medicare Covered: $40 copay IN; $40 copay POS. Routine: $0 copay IN (1 Per Year). (2 Aids Every Year IN) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay
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 max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year. $200 benefit max 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 max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year. $200 benefit max 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: Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit IN; Days 1 - 5: $270 copay per day per admit & Days 6 - 90: $0 copay per admit POS; Outpatient: $40 copay IN; $45 copay POS
Skilled Nursing Facility*	$0 copay/day (days 1-20), $196 copay/day (days 21-100) IN	$0 copay/day (days 1-20), $196 copay/day (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: $275 copay IN
Transportation* (up-to 24 one-way trips)	$0 copay IN	$0 copay IN
Part B Drugs*†	20% coinsurance IN; 30% coinsurance POS	20% coinsurance IN; 30% coinsurance POS
OTC	Not Covered	Not Covered
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	N/A	Performance

	Security Blue HMO-POS Standard	Security Blue HMO-POS Deluxe
Premium	$159.00	$220.00
Part B Premium Reduction	$0.00	$0.00
Deductible	$0	$0
Max Out-Of-Pocket	$5,000 IN; $8,950 Catastrophic	$4,500 IN; $8,950 Catastrophic
Inpatient Hospital Stay*	$335 copay per admit IN; $385 copay per admit POS	$210 copay per admit IN; $260 copay per admit POS
Outpatient Hospital Coverage*	ASC[1]: $125 copay IN; $175 Copay POS Facility: $175 copay IN; $225 copay POS	ASC[1]: $75 copay IN; $125 Copay POS Facility: $150 copay IN; $200 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: $25 copay IN; $25 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	$95 copay IN/POS	$95 copay IN/POS
Urgently Needed Services	$5 copay IN/POS	$5 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: $20 copay IN; $35 copay POS Advanced Imaging: $125 copay IN; $175 copay POS	X-ray: $15 copay IN; $30 copay POS Advanced Imaging: $75 copay IN; $125 copay POS
Hearing Services	Medicare Covered: $30 copay IN; $30 copay POS. Routine: $0 copay IN (1 Per Year). (2 Aids Every Year IN) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay	Medicare Covered: $25 copay IN; $25 copay POS. Routine: $0 copay IN (1 Per Year). (2 Aids Every Year IN) TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay
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: $25 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 max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year. $200 benefit max 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 max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year. $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services*	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
Skilled Nursing Facility*	$0 copay/day (days 1-20), $196 copay/day (days 21-100) IN	$0 copay/day (days 1-20), $196 copay/day (days 21-100) IN
Physical Therapy*	$30 copay IN; $35 copay POS	$25 copay IN; $30 copay POS
Ambulance (per one-way trip)**	Emergent/Non-Emergent: $200 copay IN	Emergent/Non-Emergent: $150 copay IN
Transportation* (up-to 24 one-way trips)	$0 copay IN	$0 copay IN
Part B Drugs*†	20% coinsurance IN; 30% coinsurance POS	20% coinsurance IN; 30% coinsurance POS
OTC	Not Covered	Not Covered
Routine Podiatry	$30 copay IN (10 visits per year)	$25 copay IN (12 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

†Certain rebatable drugs may be subject to a lower coinsurance. After 7/1/2023, Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Security Blue HMO-POS ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$300 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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$275 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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.			
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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 $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$44 Copay	$132 Copay
		Tier 4 (Insulin)	$35 Copay	$105 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 Select Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$110 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$250 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.			
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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 $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
		Tier 4 (Insulin)	$35 Copay	$105 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 Select Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$105 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$250 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.			
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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	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

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.

Health benefits or health benefit administration may be provided by or through Highmark Choice Company. Highmark Blue Cross Blue Shield provides certain administrative communications for this company. Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross Blue Shield Association. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration.

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