

Security Blue HMO and Community Blue Medicare HMO

2015 Summary of Benefits

Western Pennsylvania



**SECTION ONE:
INTRODUCTION TO SUMMARY OF BENEFITS**

Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO)

January 1, 2015 – December 31, 2015

PENNSYLVANIA

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO)**)

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO)** cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- 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 <http://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.

SECTIONS IN THIS BOOKLET

- Things to Know About **Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at (800)-935-2583. (TTY/TDD 711)

THINGS TO KNOW ABOUT COMMUNITY BLUE MEDICARE SIGNATURE (HMO) AND PRESTIGE (HMO), SECURITY BLUE VALUE (HMO), VALUERX (HMO), STANDARD (HMO) AND DELUXE (HMO)

HOURS OF OPERATION

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

COMMUNITY BLUE MEDICARE SIGNATURE (HMO) AND PRESTIGE (HMO), SECURITY BLUE VALUE (HMO), VALUERX (HMO), STANDARD (HMO) AND DELUXE (HMO) PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll-free (800)-935-2583. (TTY/TDD 711)
- If you are not a member of this plan, call toll-free (866)-682-7971. (TTY/TDD (800)-227-8210)
- Our website: <http://www.highmarkbcbs.com/medicare>

WHO CAN JOIN?

To join **Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland in Southwestern PA and Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, and Warren in West Central PA.

WHO CAN JOIN?

To join **Community Blue Medicare Signature (HMO) or Prestige (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington and Westmoreland.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue Value (HMO), ValueRx (HMO), Standard (HMO) and Deluxe (HMO) have a network of doctors, hospitals,



If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

SECTION ONE: INTRODUCTION TO SUMMARY OF BENEFITS

pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (<http://www.www.highmarkbcbs.com/medicare>).

Or, call us and we will send you a copy of the provider and pharmacy directories.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than* what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs for **Community Blue Medicare Signature (HMO) and Prestige (HMO) and for Security Blue ValueRx (HMO), Standard (HMO), and Deluxe (HMO)**. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, client.formularynavigator.com/clients/hm/default.html.
- Or, call us and we will send you a copy of the formulary.

Security Blue Value (HMO), covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

HOW WILL I DETERMINE MY DRUG COSTS?

Community Blue Medicare Signature (HMO) and Prestige (HMO), Security Blue ValueRx (HMO), Standard (HMO), and Deluxe (HMO) group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.



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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED			
How much is the monthly premium?	\$0 per month. In addition, you must keep paying your Medicare Part B premium. Keystone Health Plan West, Inc. will reduce your Medicare Part B premium by up to \$6.	\$193 per month. In addition, you must keep paying your Medicare Part B premium.	\$64-68 per month. In addition, you must keep paying your Medicare Part B premium. Please refer to the Premium Table after this section to find out the premium in your area.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
COVERED MEDICAL AND HOSPITAL BENEFITS			
	NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.	NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.	NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
SERVICES		
\$42-52 per month. In addition, you must keep paying your Medicare Part B premium. Please refer to the Premium Table after this section to find out the premium in your area.	\$201-205 per month. In addition, you must keep paying your Medicare Part B premium. Please refer to the Premium Table after this section to find out the premium in your area.	\$237-279 per month. In addition, you must keep paying your Medicare Part B premium. Please refer to the Premium Table after this section to find out the premium in your area.
This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: <ul style="list-style-type: none"> \$6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.	NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.	NOTE: • SERVICES WITH A ¹ MAY REQUIRE PRIOR AUTHORIZATION.

If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
COVERED MEDICAL AND HOSPITAL BENEFITS			
	• SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.	• SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.	• SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.
OUTPATIENT CARE AND SERVICES			
Acupuncture and Other Alternative Therapies	Not covered	Not covered	Not covered
Ambulance	\$250 copay	\$50 copay	\$100 copay
Chiropractic Care¹	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay Routine chiropractic visit (for up to 6 every year): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
Dental Services¹	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$40-300 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$25 copay Dental services: \$30 copay for a single office visit that includes: • Cleaning (for up to 1 every year) • Oral exam (for up to 1 every year)	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$10-50 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$20 copay Dental services: \$20 copay for a single office visit that includes: • Cleaning (for up to 1 every six months) • Oral exam (for up to 1 every six months)	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$30-200 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$25 copay Dental services: \$30 copay for a single office visit that includes: • Cleaning (for up to 1 every year) • Oral exam (for up to 1 every year)

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
• SERVICES WITH A ² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.		
Not covered	Not covered	Not covered
\$200 copay	\$100 copay	\$75 copay
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay Routine chiropractic visit (for up to 6 every year): \$20 copay
Dental Services ¹ Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$35-250 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$25 copay Dental services: \$30 copay for a single office visit that includes: • Cleaning (for up to 1 every year) • Oral exam (for up to 1 every year)	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$30-225 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$25 copay Dental services: \$30 copay for a single office visit that includes: • Cleaning (for up to 1 every year) • Oral exam (for up to 1 every year)	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): \$30-150 copay, depending on the service Preventive dental services: Dental x-ray(s) (for up to 1 every year): \$20 copay Dental services: \$20 copay for a single office visit that includes: • Cleaning (for up to 1 every year) • Oral exam (for up to 1 every year)

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Diabetes Supplies and Services¹	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost
Diagnostic Tests, Lab and Radiology Services, and XRays¹	Diagnostic radiology services (such as MRIs, CT scans): \$200 copay Diagnostic tests and procedures: \$5-15 copay, depending on the service Lab services: \$5-15 copay, depending on the service Outpatient x-rays: \$50 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): \$35 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: \$10 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): \$100 copay Diagnostic tests and procedures: \$0-10 copay, depending on the service Lab services: \$0-10 copay, depending on the service Outpatient x-rays: \$45 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing
Doctor's Office Visits	Primary care physician visit: \$10 copay Specialist visit: \$40 copay	Primary care physician visit: You pay nothing Specialist visit: \$10 copay	Primary care physician visit: \$5 copay Specialist visit: \$30 copay
Durable Medical Equipment <i>(wheelchairs, oxygen, etc.)¹</i>	20% of the cost	20% of the cost	20% of the cost

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost
Diagnostic radiology services (such as MRIs, CT scans): \$125 copay Diagnostic tests and procedures: \$0-10 copay, depending on the service Lab services: \$0-10 copay, depending on the service Outpatient x-rays: \$30 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): \$75 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: \$25 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing	Diagnostic radiology services (such as MRIs, CT scans): \$50 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: \$20 copay Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing
Primary care physician visit: \$10 copay Specialist visit: \$35 copay	Primary care physician visit: \$10 copay Specialist visit: \$30 copay	Primary care physician visit: \$5 copay Specialist visit: \$30 copay
20% of the cost	20% of the cost	20% of the cost

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Emergency Care	\$65 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	\$65 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	\$65 copay If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care <i>(podiatry services)</i>	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$10 copay Routine foot care (for up to 8 visit(s) every year): \$10 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$30 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: \$40 copay Routine hearing exam (for up to 1 every year): \$40 copay Hearing aid: You pay nothing Our plan pays up to \$500 every three years for hearing aids.	Exam to diagnose and treat hearing and balance issues: \$10 copay Routine hearing exam (for up to 1 every year): \$10 copay Hearing aid: You pay nothing Our plan pays up to \$1,000 every three years for hearing aids.	Exam to diagnose and treat hearing and balance issues: \$30 copay Routine hearing exam (for up to 1 every year): \$30 copay Hearing aid: You pay nothing Our plan pays up to \$500 every three years for hearing aids.
Home Health Care¹	You pay nothing	You pay nothing	You pay nothing
Mental Health Care¹	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
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Exam to diagnose and treat hearing and balance issues: \$35 copay Routine hearing exam (for up to 1 every year): \$35 copay Hearing aid: You pay nothing Our plan pays up to \$500 every three years for hearing aids.	Exam to diagnose and treat hearing and balance issues: \$30 copay Routine hearing exam (for up to 1 every year): \$30 copay Hearing aid: You pay nothing Our plan pays up to \$500 every three years for hearing aids.	Exam to diagnose and treat hearing and balance issues: \$30 copay Routine hearing exam (for up to 1 every year): \$30 copay Hearing aid: You pay nothing Our plan pays up to \$1,000 every three years for hearing aids.
You pay nothing	You pay nothing	You pay nothing
Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Mental Health Care¹ <i>(continued)</i>	<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$275 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>	<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$100 copay per stay <p>Outpatient group therapy visit: \$10 copay</p> <p>Outpatient individual therapy visit: \$10 copay</p>	<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$350 copay per stay <p>Outpatient group therapy visit: \$30 copay</p> <p>Outpatient individual therapy visit: \$30 copay</p>
Outpatient Rehabilitation¹	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$40 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$10 copay</p> <p>Physical therapy and speech and language therapy visit: \$10 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$30 copay</p> <p>Physical therapy and speech and language therapy visit: \$30 copay</p>
Outpatient Substance Abuse¹	Group therapy visit: \$40 copay	Group therapy visit: \$10 copay	Group therapy visit: \$30 copay

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$200 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 <p>Outpatient group therapy visit: \$35 copay</p> <p>Outpatient individual therapy visit: \$35 copay</p>	<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$325 copay per stay <p>Outpatient group therapy visit: \$30 copay</p> <p>Outpatient individual therapy visit: \$30 copay</p>	<p>inpatient mental services provided in a general hospital.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> • \$225 copay per stay <p>Outpatient group therapy visit: \$30 copay</p> <p>Outpatient individual therapy visit: \$30 copay</p>
<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$35 copay</p> <p>Physical therapy and speech and language therapy visit: \$35 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$30 copay</p> <p>Physical therapy and speech and language therapy visit: \$30 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing</p> <p>Occupational therapy visit: \$30 copay</p> <p>Physical therapy and speech and language therapy visit: \$30 copay</p>
Group therapy visit: \$35 copay	Group therapy visit: \$30 copay	Group therapy visit: \$30 copay

If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Outpatient Substance Abuse¹ <i>(continued)</i>	Individual therapy visit: \$40 copay	Individual therapy visit: \$10 copay	Individual therapy visit: \$30 copay
Outpatient Surgery¹	Ambulatory surgical center: \$300 copay Outpatient hospital: \$300 copay	Ambulatory surgical center: \$50 copay Outpatient hospital: \$50 copay	Ambulatory surgical center: \$100 copay Outpatient hospital: \$200 copay
Over-the-Counter Items	Not Covered	Not Covered	Not Covered
Prosthetic Devices <i>(braces, artificial limbs, etc.)¹</i>	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis	You pay nothing	You pay nothing	You pay nothing
Transportation	\$40 copay	\$40 copay	\$40 copay
Urgent Care	\$50 copay	\$50 copay	\$50 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-40 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-10 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-30 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
Individual therapy visit: \$35 copay	Individual therapy visit: \$30 copay	Individual therapy visit: \$30 copay
Ambulatory surgical center: \$150 copay Outpatient hospital: \$250 copay	Ambulatory surgical center: \$125 copay Outpatient hospital: \$225 copay	Ambulatory surgical center: \$75 copay Outpatient hospital: \$150 copay
Not Covered	Not Covered	Not Covered
Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
You pay nothing	You pay nothing	You pay nothing
\$40 copay	\$40 copay	\$40 copay
\$50 copay	\$50 copay	\$50 copay
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-35 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-30 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$0-30 copay, depending on the service Routine eye exam (for up to 1 every year): You pay nothing Contact lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for contact lenses.

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Vision Services <i>(continued)</i>	Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing	Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing	Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing
Preventive Care	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings 	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings 	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing	Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing	Eyeglass frames (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass frames. Eyeglass lenses (for up to 1 every year): You pay nothing Our plan pays up to \$100 every year for eyeglass lenses. Eyeglasses or contact lenses after cataract surgery: You pay nothing
You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings 	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings 	You pay nothing Our plan covers many preventive services, including: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Preventive Care <i>(continued)</i>	<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
OUTPATIENT CARE AND SERVICES			
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
INPATIENT CARE			
Inpatient Hospital Care¹	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$275 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond 	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$100 copay per stay • You pay nothing per day for days 91 and beyond 	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$350 copay per stay • You pay nothing per day for days 91 and beyond
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)¹	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$155 copay per day for days 21-100 	Our plan covers up to 100 days in a SNF. (SNF) ¹ <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$150 copay per day for days 21-100 	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$150 copay per day for days 21-100
PRESCRIPTION DRUG BENEFITS			
How much do I pay?	For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug Our plan does not cover Part D prescription drug.

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$200 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • You pay nothing per day for days 91 and beyond 	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$325 copay per stay • You pay nothing per day for days 91 and beyond 	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> • \$225 copay per stay • You pay nothing per day for days 91 and beyond
For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$150 copay per day for days 21-100 	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$150 copay per day for days 21-100 	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> • \$0 copay per day for days 1-20 • \$150 copay per day for days 21-100
For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug	For Part B drugs such as chemotherapy drugs ¹ : 0-20% of the cost depending on the drug Other Part B drugs ¹ : 0-20% of the cost depending on the drug

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BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
PRESCRIPTION DRUG BENEFITS			
Initial Coverage	You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	
	Standard Retail Cost-Sharing Tier	Standard Retail Cost-Sharing Tier	
	One-month supply	One-month supply	
	Tier 1 (Preferred Generic) \$4 copay	Tier 1 (Preferred Generic) \$3 copay	
	Tier 2 (Non-Preferred Generic) \$15 copay	Tier 2 (Non-Preferred Generic) \$12 copay	
	Tier 3 (Preferred Brand) \$45 copay	Tier 3 (Preferred Brand) \$40 copay	
	Tier 4 ((Non-Preferred Brand) \$95 copay	Tier 4 ((Non-Preferred Brand) \$90 copay	
	Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost	
	Three-month supply	Three-month supply	
	Tier 1 (Preferred Generic) \$12 copay	Tier 1 (Preferred Generic) \$9 copay	
	Tier 2 (Non-Preferred Generic) \$45 copay	Tier 2 (Non-Preferred Generic) \$36 copay	
	Tier 3 (Preferred Brand) \$135 copay	Tier 3 (Preferred Brand) \$120 copay	
	Tier 4 ((Non-Preferred Brand) \$285 copay	Tier 4 ((Non-Preferred Brand) \$270 copay	
	Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost	

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach \$2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.
Standard Retail Cost-Sharing Tier	Standard Retail Cost-Sharing Tier	Standard Retail Cost-Sharing Tier
One-month supply	One-month supply	One-month supply
Tier 1 (Preferred Generic) \$4 copay	Tier 1 (Preferred Generic) \$4 copay	Tier 1 (Preferred Generic) \$4 copay
Tier 2 (Non-Preferred Generic) \$12 copay	Tier 2 (Non-Preferred Generic) \$12 copay	Tier 2 (Non-Preferred Generic) \$12 copay
Tier 3 (Preferred Brand) \$45 copay	Tier 3 (Preferred Brand) \$45 copay	Tier 3 (Preferred Brand) \$42 copay
Tier 4 ((Non-Preferred Brand) \$95 copay	Tier 4 ((Non-Preferred Brand) \$90 copay	Tier 4 ((Non-Preferred Brand) \$90 copay
Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost
Three-month supply	Three-month supply	Three-month supply
Tier 1 (Preferred Generic) \$12 copay	Tier 1 (Preferred Generic) \$12 copay	Tier 1 (Preferred Generic) \$12 copay
Tier 2 (Non-Preferred Generic) \$36 copay	Tier 2 (Non-Preferred Generic) \$36 copay	Tier 2 (Non-Preferred Generic) \$36 copay
Tier 3 (Preferred Brand) \$135 copay	Tier 3 (Preferred Brand) \$135 copay	Tier 3 (Preferred Brand) \$126 copay
Tier 4 ((Non-Preferred Brand) \$285 copay	Tier 4 ((Non-Preferred Brand) \$270 copay	Tier 4 ((Non-Preferred Brand) \$270 copay
Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost	Tier 5 (Specialty Tier) 33% of the cost

If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
PRESCRIPTION DRUG BENEFITS			
Initial Coverage <i>(continued)</i>	Standard Mail Order Cost-Sharing Three-month supply Tier 1 (Preferred Generic) \$10 copay Tier 2 (Non-Preferred Generic) \$30 copay Tier 3 (Preferred Brand) \$112.50 copay Tier 4 (Non-Preferred Brand) \$237.50 copay Tier 5 (Specialty Tier) 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	Standard Mail Order Cost-Sharing Three-month supply Tier 1 (Preferred Generic) \$7.50 copay Tier 2 (Non-Preferred Generic) \$30 copay Tier 3 (Preferred Brand) \$100 copay Tier 4 (Non-Preferred Brand) \$225 copay Tier 5 (Specialty Tier) 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total \$4,700, which is	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total \$4,700, which is	

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
Standard Mail Order Cost-Sharing Three-month supply Tier 1 (Preferred Generic) \$10 copay Tier 2 (Non-Preferred Generic) \$30 copay Tier 3 (Preferred Brand) \$112.50 copay Tier 4 (Non-Preferred Brand) \$237.50 copay Tier 5 (Specialty Tier) 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	Standard Mail Order Cost-Sharing Three-month supply Tier 1 (Preferred Generic) \$10 copay Tier 2 (Non-Preferred Generic) \$30 copay Tier 3 (Preferred Brand) \$112.50 copay Tier 4 (Non-Preferred Brand) \$225 copay Tier 5 (Specialty Tier) 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	Standard Mail Order Cost-Sharing Three-month supply Tier 1 (Preferred Generic) \$10 copay Tier 2 (Non-Preferred Generic) \$30 copay Tier 3 (Preferred Brand) \$105 copay Tier 4 (Non-Preferred Brand) \$225 copay Tier 5 (Specialty Tier) 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total \$4,700, which is	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total \$4,700, which is	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$2,960. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 65% of the plan’s cost for covered generic drugs until your costs total \$4,700, which is

If you have any questions about this plan’s benefits or costs, please contact Keystone Health Plan West, Inc. for details.

BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
PRESCRIPTION DRUG BENEFITS			
Coverage Gap <i>(continued)</i>	the end of the coverage gap. Not everyone will enter the coverage gap.	<p>the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard Retail Cost-Sharing</p> <p>Drugs Covered All</p> <p>One-month supply Tier 1 (Preferred Generic) \$3 copay</p> <p>Tier 2 (Non-Preferred Generic) \$12 copay</p> <p>Drugs Covered All</p> <p>Three-month supply Tier 1 (Preferred Generic) \$9 copay</p> <p>Tier 2 (Non-Preferred Generic) \$36 copay</p> <p>Standard Mail Order Cost-Sharing</p> <p>Drugs Covered All</p> <p>Three-month supply Tier 1 (Preferred Generic) \$7.50 copay</p> <p>Tier 2 (Non-Preferred Generic) \$30 copay</p>	

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
the end of the coverage gap. Not everyone will enter the coverage gap.	the end of the coverage gap. Not everyone will enter the coverage gap.	<p>the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard Retail Cost-Sharing</p> <p>Drugs Covered All</p> <p>One-month supply Tier 1 (Preferred Generic) \$4 copay</p> <p>Tier 2 (Non-Preferred Generic) \$12 copay</p> <p>Drugs Covered All</p> <p>Three-month supply Tier 1 (Preferred Generic) \$12 copay</p> <p>Tier 2 (Non-Preferred Generic) \$36 copay</p> <p>Standard Mail Order Cost-Sharing</p> <p>Drugs Covered All</p> <p>Three-month supply Tier 1 (Preferred Generic) \$10 copay</p> <p>Tier 2 (Non-Preferred Generic) \$30 copay</p>

If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

BENEFIT CATEGORY	COMMUNITY BLUE MEDICARE SIGNATURE (HMO)	COMMUNITY BLUE MEDICARE PRESTIGE (HMO)	SECURITY BLUE VALUE (HMO)
PRESCRIPTION DRUG BENEFITS			
Catastrophic Coverage	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs. 	

SECURITY BLUE VALUERX (HMO)	SECURITY BLUE STANDARD (HMO)	SECURITY BLUE DELUXE (HMO)
<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs. 	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.65 copay for generic (including brand drugs treated as generic) and a \$6.60 copayment for all other drugs.

If you have any questions about this plan's benefits or costs, please contact Keystone Health Plan West, Inc. for details.

PREMIUM TABLE

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve.

The service area for Community Blue Medicare HMO includes the following counties: Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington and Westmoreland.

	Premium
Community Blue Medicare Signature (HMO)	\$0
Community Blue Medicare Prestige (HMO)	\$193

The service area for Security Blue HMO in Southwestern, PA includes the following counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland.

The service area for Security Blue HMO in West Central, PA includes the following counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango and Warren.

	Southwestern, PA Premium	West Central, PA Premium
Security Blue Value (HMO)	\$68	\$64
Security Blue ValueRx (HMO)	\$52	\$42
Security Blue Standard (HMO)	\$205	\$201
Security Blue Deluxe (HMO)	\$279	\$237

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-456-3738. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-456-3738. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-866-456-3738。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-866-456-3738。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-456-3738. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-456-3738. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-866-456-3738 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-456-3738. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-456-3738 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-456-3738. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على 3738-456-866-1 على 1-866-456-3738. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-456-3738. سيقوم شخص ما يتحدث العربية بخدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-456-3738. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-456-3738. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-456-3738. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-456-3738. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-456-3738 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-866-456-3738にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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