HIGHMARK

West Central Pennsylvania

Security Blue HMO-POS

Summary of Benefits

January 1, 2026 to December 31, 2026

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

Bedford, Blair, Cameron, Clarion, Clearfield, Elk, Huntingdon, Jefferson, Somerset

This summary of benefits doesn't list every service, limitation, or special circumstance.

Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-935-2583** (TTY 711). We're available 7 days a week, 8 a.m. to 8 p.m.

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 **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

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

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	Security Blue HMO-POS ValueRx (HMO-POS)
Premium	$36
Part B Premium Reduction	$1
Deductible	$0
Max Out-Of-Pocket	$5,500 IN; $8,950 combined IN and POS
Inpatient Hospital Stay*	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]: $175 copay IN; $225 copay POS Facility: $200 copay IN; $250 copay POS
Doctor Office Visit	PCP: $0 copay IN; $0 copay POS Specialist: $35 copay IN; $40 copay POS
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/POS
Emergency Room	$130 copay IN/POS
Urgently Needed Services	$50 copay IN/POS
Lab* & Diagnostic Tests*	Freestanding Lab: $0 copay IN; $25 copay POS Office/Outpatient: $5 copay IN; $25 copay POS
X-Rays*/ Advanced Imaging*	X-ray: $20 copay IN; $25 copay POS Advanced Imaging: $175 copay IN; $225 copay POS
Hearing Services	Medicare Covered: $35 copay IN; $40 copay POS. Routine: $0 copay IN (1 Per Year). TruHearing Advanced: $599 copay; (2 Aids Every Year IN/POS) TruHearing Premium: $899 copay (2 Aids Every Year IN/POS)
Dental Services	Medicare Covered: $35 copay IN. Routine Office Visit/X-Ray: $15 copay (for any combination of oral exam, x-ray, and cleaning provided in a single visit). IN (2 per year) Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN
Vision Services	Medicare Covered: $35 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 $225 benefit max applies to non-standard frames or a $225 benefit max applies to specialty contact lenses per year. $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	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), $218 copay/day (days 21 - 100) IN
Physical Therapy	$10 copay IN*; $45 copay POS
Ambulance (per one-way trip)*(**)	Emergent/Non-Emergent: $340 copay IN
Transportation* (up-to 24 one-way trips)	$0 copay IN
Medicare Part B Drugs*†	20% coinsurance IN; 30% coinsurance POS
Durable Medical Equipment*	20% coinsurance IN
Formulary	Performance

*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. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Security Blue HMO-POS ValueRx (HMO-POS)

DRUG

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		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)	35% of the cost	35% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		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)	35% of the cost	35% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		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	35% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		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	35% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

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

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. The Blue Cross®, Blue Shield®, Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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 and/or to one or more of its affiliated Blue companies.

This information is not a complete description of benefits. Call 1-866-746-7971 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.