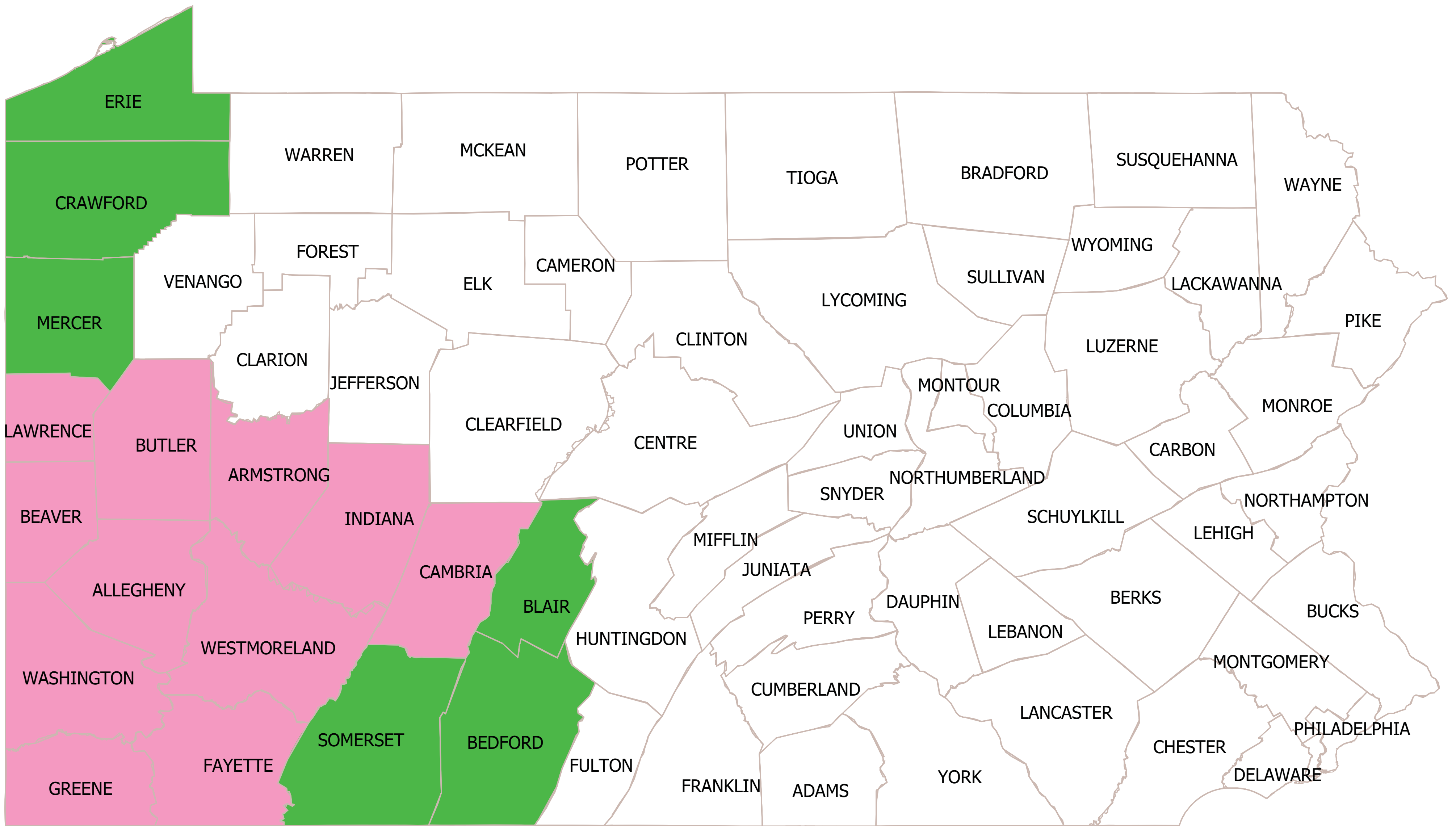
SecurityBlue HMO

	Value	Basic	Standard	Deluxe	Care*
Premium (By Region)	$30 - SW $25 - NC	$49 - SW $43 - NC	$119 - SW $120 - NC	$183 - SW $151 - NC	$0 - SW $0 - NC
PCP Office Visit	$10 Per Visit	$10 Per Visit	$15 Per Visit	$5 Per Visit	Covered in Full
Specialist Office Visit	$30 Per Visit	$40 Per Visit	$30 Per Visit	$25 Per Visit	Covered in Full
Diagnostic Tests	$20 Copay	$20 Copay	$20 Copay	$10 Copay	80% Coverage after Part B ded.
X-Rays/Advanced Imaging	$30 X-Ray/$75 Advanced Imaging	$20 X-Ray/$75 Advanced Imaging	$20 X-Ray/$50 Advanced Imaging	$10 X-Ray/$30 Advanced Imaging	80% Coverage after Part B ded.
Preventive/Screening *(Mammograms, PAP Test, Colorectal, Prostate, Immunizations - Flu/Pneumonia)*	Covered In Full *(Office visit copay may apply)*	Covered In Full *(Office visit copay may apply)*	Covered In Full *(Office visit copay may apply)*	Covered In Full *(Office visit copay may apply)*	80% (Mammograms, colorectal, prostate, bone mass measure, Hepatitis B vacc), after Part B ded. 100% (pelvic exam, pap test, immunizations-Flu/Pneumonia)
Outpatient Rehab	$30 Copay	$40 Copay	$30 Copay	$25 Copay	80% Coverage after Part B ded.
Outpatient Surgical	$150 Copay	$150 Copay	$125 Copay	$50 Copay	80% Coverage after Part B ded.
Ambulance *(per one way trip)*	$100 Copay	$100 Copay	$100 Copay	$75 Copay	80% Coverage after Part B ded.
Emergency Room	$50 Copay	$50 Copay	$50 Copay	$50 Copay	80% Coverage after Part B ded.
Inpatient Hospital Stay	$200/admit, $600 OOP Max	$300/admit, $900 OOP Max	$200/admit, $400 OOP Max	$100/admit, $200 OOP Max	$1,068** deductible - Days 1-60 $267**/ day - Days 61-90 $534**/ day - Days 91-150
Skilled Nursing Facility *(days 1-100 per benefit period)*	$60/day (days 16-55)/admit $2,400 OOP Max	$75/day (days 16-55)/admit $3,000 OOP Max	$60/day (days 16-55)/admit $2,400 OOP Max	$40/day (days 16-55)/admit $1,600 OOP Max	Days 1-20 -100% Days 21-100-$133.50**/day
Home Health	Covered In Full *(when part of approved plan of care)*	Covered In Full *(when part of approved plan of care)*	Covered In Full *(when part of approved plan of care)*	Covered In Full *(when part of approved plan of care)*	Covered In Full *(when part of approved plan of care)*
Durable Medical Equipment	15% coinsurance, $750 OOP Max	15% coinsurance, $750 OOP Max	15% coinsurance, $750 OOP Max	15% coinsurance, $500 OOP Max	80% after Part B Ded. (DMEnsions claims are not subject to deductible)
Routine Vision	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses
Routine Hearing	$500 for hearing aid(s) every 3 years	$500 for hearing aid(s) every 3 years	$500 for hearing aid(s) every 3 years	$1,000 for hearing aid(s) every 3 years	$1,500 for hearing aid(s) every 3 years
Routine Dental	Not Covered	Not Covered	Not Covered	40% coinsurance 50% denture co-insurance	100% plan coverage, $1,000 annual benefit maximum
Routine Chiro/Podiatry	Not Covered	Not Covered	Not Covered	Routine Podiatry: 8 per calendar year Routine Chiro: 6 per calendar year.	Not Covered
Part D Drugs *(Up to 34 Days)*					**Coverage Level Varies Based on LIS Status**
Initial Coverage *(Up to $2,830 in total Rx Costs)*	Not Covered	$7 Generic, $42 Preferred Brand, $90 Non-Pref Brand, 33% Specialty	$7 Generic, $42 Preferred Brand, $80 Non-Pref Brand, 33% Specialty	$7 Generic, $40 Preferred Brand, $80 Non-Pref Brand, 33% Specialty	$0/ $1.10/$3.30 $2.50/$6.30 Generic/Preferred Multi-Source
Coverage Gap *(From $2,830 in total Rx Costs to $4,550 Member OOP)*	Not Covered	Not Covered	Not Covered	Generics Covered ($7)	$0/ $1.10/$3.30 $2.50/$6.30 Generic/Preferred Multi-Source
Catastrophic Coverage *(From $4,550 Member OOP)*	Not Covered	Greater of: 5% or $2.50 Gen/Multi Source or $6.30 for all others	Greater of: 5% or $2.50 Gen/Multi Source or $6.30 for all others	Greater of: 5% or $2.50 Gen/Multi Source or $6.30 for all others	Not Covered
Mail Order Drugs *(Initial Coverage Period) - Up to 90 Days)*	Not Covered	$17.50 Generic, $105 Preferred Brand, $225 Non-Pref Brand, 33% Specialty	$17.50 Generic, $105 Preferred Brand, $200 Non-Pref Brand, 33% Specialty	$17.50 Generic, $100 Preferred Brand, $200 Non-Pref Brand, 33% Specialty	$0/ $1.10/$3.30 $2.50/$6.30 Generic/Preferred Multi-Source

SecurityBlue Regions:
SW (Southwest) - Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland Counties
NC (North Central) - Bedford, Blair, Crawford, Erie, Mercer, and Somerset Counties

* 20% Coinsurance to be paid by Medicaid, up to the Medicaid allowable amount. Providers should bill Medicaid or accept plan payment as payment in full.
** These are the 2009 Medicare deductibles and copayments, they will change if Medicare announces a change for 2010.

Internal and Agent Use Only - Not For Distribution



SecurityBlue HMO Service Area

Southwest

North Central