

SecurityBlue HMO

	Value	HD	ValueRx	Standard	Deluxe	Care*
Premium (By Region)	\$30 - SW	\$0 - All Regions	\$66 - SW	\$142 - SW	\$208 - SW	\$0 - In 17 Counties
	\$25 - WC	SW - \$1,450 Deductible	\$60 - WC	\$143 - WC	\$175 - WC	(\$32.50 Part D premium. CMS assists with Part D premium costs)
		WC - \$1,250 Deductible				
PCP Office Visit	\$10 Per Visit	\$15 per visit	\$10 (SW), \$5 (WC) Per Visit	\$10 Per Visit	\$5 Per Visit	80-100% Coverage after Part B ded.
Specialist Office Visit	\$30 Per Visit	\$25 per visit	\$40 Per Visit	\$25 Per Visit	\$25 Per Visit	80-100% Coverage after Part B ded.
Lab & Diagnostic Tests	\$20 Copay	Covered in full after deductible	\$20 Copay	Covered in Full	Covered in Full	100% Coverage for Medicare-approved lab services 80% Coverage after Part B ded. For diagnostic tests
X-Rays/Advanced Imaging	\$30 X-Ray/\$75 Advanced Imaging	Covered in full after deductible	\$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 <i>(Mammograms, PAP Test, Colorectal, Prostate, Immunizations - Flu/Pneumonia)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit cost sharing may apply)</i>
Outpatient Rehab	\$30 Copay	Covered in full after deductible	\$40 Copay	\$25 Copay	\$25 Copay	80% Coverage after Part B ded.
Outpatient Surgical	\$150 Copay	Covered in full after deductible	\$150 Copay	\$100 Copay	\$50 Copay	80% Coverage after Part B ded.
Ambulance <i>(per one way trip)</i>	\$100 Copay	\$75 Copay	\$100 Copay	\$100 Copay	\$75 Copay	80% Coverage after Part B ded.
Transportation <i>(Wheelchair Van per one way trip)</i>	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Emergency Room	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	80% Coverage after Part B ded.
Inpatient Hospital Stay	\$200/admit	Covered in full after deductible	\$350/admit	\$200/admit	\$100/admit	\$1,100** deductible - Days 1-60 \$275**/ day - Days 61-90 \$550**/ day - Days 91-150
Skilled Nursing Facility <i>(days 1-100 per benefit period)</i>	\$60/day (days 16-55)/admit	Covered in full after deductible	\$75/day (days 16-55)/admit	\$60/day (days 16-55)/admit	\$40/day (days 16-55)/admit	Days 1-20-100% Days 21-100-\$137.50**/day
Home Health	Covered In Full <i>(when part of approved plan of care)</i>	Covered In full after deductible <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>
Durable Medical Equipment	15% coinsurance	Covered in full after deductible	15% coinsurance	15% coinsurance	15% coinsurance	80% after Part B Ded. (DME claims are not subject to deductible)
Routine Vision <i>(every 2 years)</i>	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	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 yrs	\$500 for hearing aid(s) every 3 yrs	\$500 for hearing aid(s) every 3 yrs	\$500 for hearing aid(s) every 3 yrs	\$1,000 for hearing aid(s) every 3 yrs	\$1,000 for hearing aid(s) every 3 yrs
Routine Dental	Not Covered	40% coinsurance;50% coinsurance for dentures	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	Not Covered	Routine Podiatry: 8 per calendar yr Routine Chiro: 6 per calendar yr	Not Covered
Maximum OOP	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max
Part D Drugs <i>(Up to 34 Days)</i>						Coverage Level Varies Based on LIS Status
Initial Coverage <i>(Up to \$2,840 in total Rx Costs)</i>	Not Covered	\$7 Generic, \$42 Preferred Brand, \$90 Non-Pref Brand, 33% Specialty	\$10 Generic, \$45 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 <i>(From \$2,840 in total Rx Costs to \$4,550 Member OOP)</i>	Not Covered	Generics (93% coins) Brand Discount (50%) ¹	Generics (93% coins) Brand Discount (50%) ¹	Generics (93% coins) Brand Discount (50%) ¹	Generics Covered (\$7) Brand Discount (50%) ¹	\$0/ \$1.10/\$3.30 \$2.50/\$6.30 Generic/Preferred Multi-Source
Catastrophic Coverage <i>(From \$4,550 Member OOP)</i>	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	Greater of: 5% or \$2.50 Gen/Multi Source or \$6.30 for all others	Not Covered
Mail Order Drugs <i>(Initial Coverage Period) - Up to 90 Days)</i>	Not Covered	\$17.50 Generic, \$105 Preferred Brand, \$225 Non-Pref Brand, 33% Specialty	\$25 Generic, \$112.50 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:

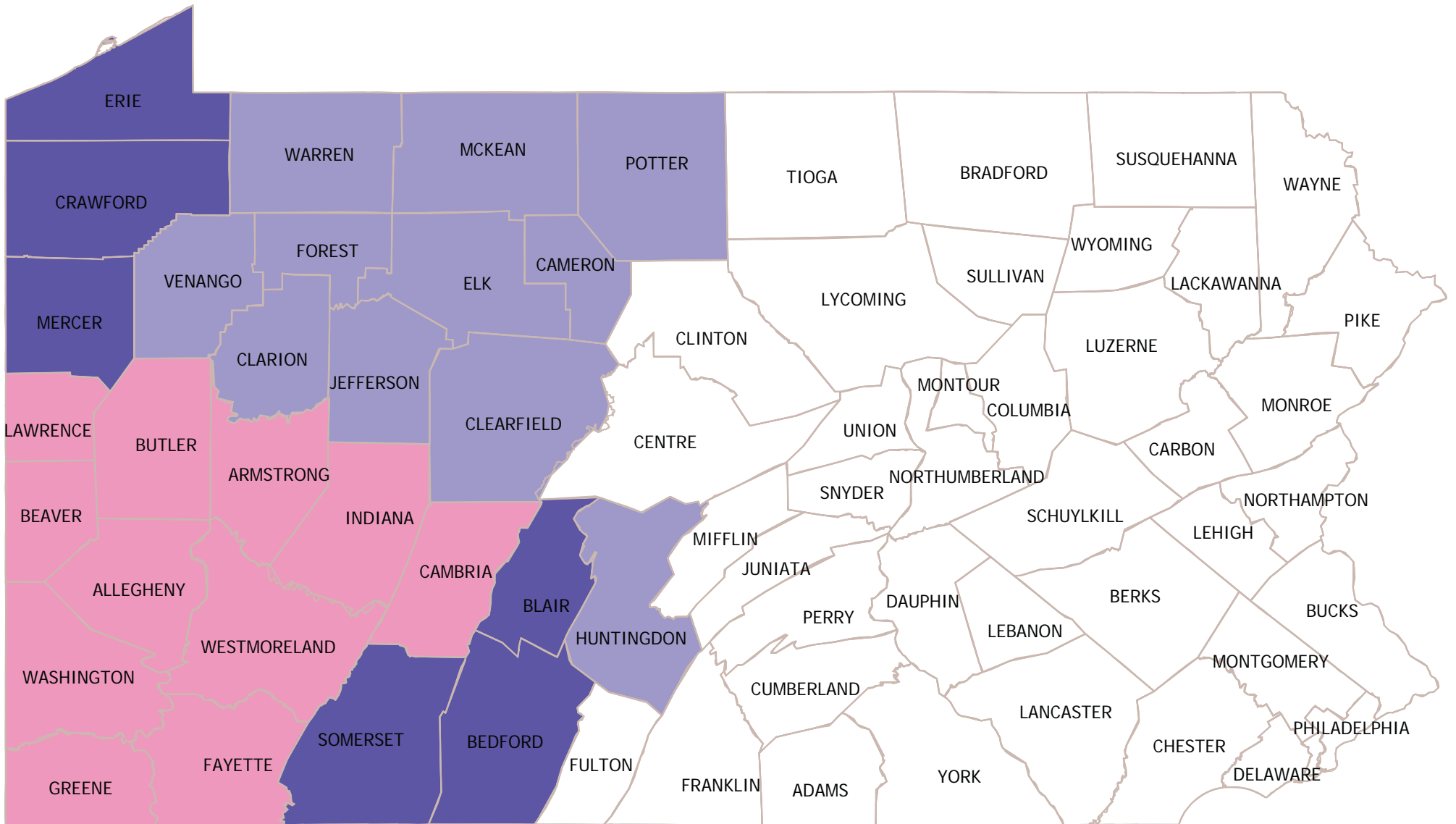
SW (Southwest) - Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties

WC (West Central) - Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango and Warren counties

¹ The Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee) will be

* 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 2010 Medicare deductibles and copayments, they will change if Medicare announces a change for 2011.



SecurityBlue HMO Service Area

- Southwest**
- West Central**
- West Central (SBHMO Care Not Available)**