HIGHMARK MEDICARE SOLUTIONS

Community Blue Medicare HMO (Western, Central and Northeastern Pennsylvania)

			Community Blue Medicare HMO Signature	Community Blue Medicare HMO Prestige	Community Blue Medicare HMO Signature
HEALTH	BASIC PLAN COSTS	**Monthly Plan Premium**	Western: $0	Western: $193	Central/NEPA Region 1: $15 Central/NEPA Region 2: $25
		Out-of-Pocket Maximum	$6,700	$6,700	$6,700
	PHYSICIAN SERVICES	**Doctor Office Visit**	$0 Per Visit	$0 Per Visit	$5 Per Visit
		Specialist Office Visit	$45 Per Visit	$10 Per Visit	$45 Per Visit
		Lab & Diagnostic Test	Office/Lab: $5 Copay Outpatient: $20 Copay	Covered in Full	Office/Lab: $5 Copay Outpatient: $20 Copay
		X-rays/Advanced Imaging	$50 X-Ray/$200 Advanced Imaging	$10 X-Ray/$35 Advanced Imaging	$50 X-Ray/$200 Advanced Imaging
		Preventative Testings & Screenings	Covered In Full	Covered In Full	Covered In Full
	FACILITY SERVICES	**Outpatient Surgery**	ASC: $350 Copay Facility: $350 Copay	ASC: $50 Copay Facility: $50 Copay	ASC: $300 Copay Facility: $300 Copay
		Emergency Room	$75 Copay	$75 Copay	$75 Copay
		Inpatient Hospital Stay	$275/day (days 1-5)/admit	$100/admit	$200/day (days 1-7)/admit
		Skilled Nursing Facility ***(days 1-100 per benefit period per admit)***	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)
	ADDITIONAL BENEFITS	**Routine Vision** ***(annually)***	$0 Copay for routine eye exam. 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. $200 benefit maximum for post cataract eyewear.		
		Routine Hearing ***(2 hearing aids per year)***	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $499 copay per aid TruHearing Chime 900: $799 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid
		Routine Dental	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $20 Copay (1 every 6 months) X-Ray: $20 Copay (1 every 6 months)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)
		Routine Chiropractic	$20 Copay (6 visits)	$20 Copay (8 visits)	$20 Copay (6 visits)
		Routine Podiatry	$45 Copay (8 visits)	$10 Copay (10 visits)	$45 Copay (8 visits)
		Acupuncture	$30 Copay (5 visits)	$30 Copay (5 visits)	$30 Copay (5 visits)
	OTHER PLAN COVERAGE	**Ambulance** ***(per one way trip)***	$300 Copay	$100 Copay	$300 Copay
		Durable Medical Equipment ***(including oxygen)***	20% Coinsurance	20% Coinsurance	20% Coinsurance
DRUG	PART D DRUGS (UP TO 31 DAYS)	**Initial Coverage**	$0 Pref. Gen, $20 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $42 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$5 Pref. Gen, $20 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty
		Coverage Gap	Generics (58% coins) Brand (45% coins including 50% discount)	Generics: Tier 1 ($3) Generics: Tier 2 ($15) Generics Tiers 3-5 (58% coins) Brand (45% coins including 50% discount)	Generics (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs ***(up to 90 day supply; specialty tier up to 31 days supply)***	$0 Pref. Gen, $50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $105 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$12.50 Pref. Gen, $50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty

PENDING CMS APPROVAL

Western Counties: Allegheny, Armstrong, Beaver, Bedford, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington, Westmoreland

Central/NEPA 1 Counties: Cumberland, Dauphin, Lackawanna, Lehigh, Luzerne, Lycoming, Sullivan, Wyoming

Central/NEPA 2 Counties: Juniata, Northampton, Perry, Susquehanna, Tioga, Wayne

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HIGHMARK. MEDICARE SOLUTIONS

Security Blue HMO (Western Pennsylvania)

			Security Blue HMO Basic	Security Blue HMO ValueRx	Security Blue HMO Standard	Security Blue HMO Deluxe
HEALTH	BASIC PLAN COSTS	**Monthly Plan Premium**	SW: $44 WC: $44	SW: $59 WC: $49	SW: $195 WC: $174	SW: $270 WC: $214
		Out-of-Pocket Maximum	$6,700	$6,700	$6,700	$6,700
	PHYSICIAN SERVICES	**Doctor Office Visit**	$5 Per Visit	$10 Per Visit	$10 Per Visit	$5 Per Visit
		Specialist Office Visit	$30 Per Visit	$35 Per Visit	$30 Per Visit	$25 Per Visit
		Lab & Diagnostic Test	Office/Lab: $0 Copay Outpatient: $10 Copay	Office/Lab: $0 Copay Outpatient: $10 Copay	Covered in Full	Covered in Full
		X-rays/Advanced Imaging	$45 X-Ray/$100 Advanced Imaging	$30 X-Ray/$125 Advanced Imaging	$25 X-Ray/$75 Advanced Imaging	$20 X-Ray/$50 Advanced Imaging
		Preventative Testings & Screenings	Covered In Full	Covered In Full	Covered In Full	Covered In Full
	FACILITY SERVICES	**Outpatient Surgery**	ASC: $100 Copay Facility: $200 Copay	ASC: $135 Copay Facility: $250 Copay	ASC: $125 Copay Facility: $225 Copay	ASC: $75 Copay Facility: $150 Copay
		Emergency Room	$75 Copay	$75 Copay	$75 Copay	$75 Copay
		Inpatient Hospital Stay	$350/admit	$200/day (days 1-7)/admit	$325/admit	$225/admit
		Skilled Nursing Facility ***(days 1-100 per benefit period per admit)***	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)
	ADDITIONAL BENEFITS	**Routine Vision** ***(annually)***	$0 Copay for routine eye exam. 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. $200 benefit maximum for post cataract eyewear.			
		Routine Hearing ***(2 hearing aids per year)***	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $499 copay per aid TruHearing Chime 900: $799 copay per aid
		Routine Dental	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $20 Copay (1 every calendar year) X-Ray: $20 Copay (1 every calendar year)
		Routine Chiropractic	$20 Copay (6 visits)	$20 Copay (6 visits)	$20 Copay (8 visits)	$20 Copay (8 visits)
		Routine Podiatry	$30 Copay (8 visits)	$35 Copay (8 visits)	$30 Copay (10 visits)	$25 Copay (10 visits)
	OTHER PLAN COVERAGE	**Ambulance** ***(per one way trip)***	$125 Copay	$200 Copay	$125 Copay	$100 Copay
		Durable Medical Equipment ***(including oxygen)***	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
DRUG	PART D DRUGS (UP TO 31 DAYS)	**Initial Coverage**	Not Covered	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $45 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $42 Pref. Brand, 45% Non-Pref Brand, 33% Specialty
		Coverage Gap	Not Covered	Generics (58% coins) Brand (45% coins including 50% discount)	Generics (58% coins) Brand (45% coins including 50% discount)	Generics: Tier 1 ($3) Generics: Tier 2 ($15) Generics Tiers 3-5 (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage	Not Covered	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs ***(up to 90 day supply; specialty tier up to 31 days supply)***	Not Covered	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $112.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $105 Pref. Brand, 45% Non-Pref Brand, 33% Specialty

SW Counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland
WC Counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, Warren

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PENDING CMS APPROVAL

HIGHMARK. MEDICARE SOLUTIONS

Freedom Blue PPO (Western Pennsylvania)

			Freedom Blue PPO ValueRx	Freedom Blue PPO Select	Freedom Blue PPO Classic
HEALTH	BASIC PLAN COSTS	**Monthly Plan Premium**	SW: $79 WC: $69	SW: $174 WC: $127	SW: $299 WC: $269
		Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000
		Out-of-Network	30% OON Coinsurance (unless otherwise noted)	30% OON Coinsurance	30% OON Coinsurance
	PHYSICIAN SERVICES	**Doctor Office Visit**	$15 IN; $20 OON	$10 IN; $20 OON	$5 IN; $10 OON
		Specialist Office Visit	$40 IN; $45 OON	$30 IN; $45 OON	$25 IN; $40 OON
		Lab & Diagnostic Test	Office/Lab: $5 Copay Outpatient: $15 Copay	Office/Lab: $0 Copay Outpatient: $10 Copay	Covered in Full
		X-rays/Advanced Imaging	$50 X-Ray/$200 Advanced Imaging	$40 X-Ray/$150 Advanced Imaging	$20 X-Ray/$100 Advanced Imaging
		Preventative Testings & Screenings	Covered In Full	Covered In Full	Covered In Full
	FACILITY SERVICES	**Outpatient Surgery**	ASC: $200 Copay Facility: $300 Copay	ASC: $150 Copay Facility: $250 Copay	ASC: $150 Copay Facility: $250 Copay
		Emergency Room	$75 Copay	$75 Copay	$75 Copay
		Inpatient Hospital Stay	$250/day (days 1-5)/admit OON: 10% coinsurance	$200/day (days 1-5)/admit	$125/day (days 1-5)/admit
		Skilled Nursing Facility ***(days 1-100 per benefit period per admit)***	$0/day (days 1-20) $160/day (days 21-100)	$0/day (days 1-20) $160/day (days 21-100)	$0/day (days 1-20) $160/day (days 21-100)
	ADDITIONAL BENEFITS	**Routine Vision** ***(annually)***	$0 Copay for routine eye exam. 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. $200 benefit maximum for post cataract eyewear.		
		Routine Hearing ***(2 hearing aids per year)***	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid
		Routine Dental	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $20 Copay (1 every calendar year) X-Ray: $20 Copay (1 every calendar year)
		Routine Chiropractic	$20 Copay (8 visits)	$20 Copay (8 visits)	$20 Copay (8 visits)
		Routine Podiatry	$40 Copay (10 visits)	$30 Copay (10 visits)	$25 Copay (10 visits)
	OTHER PLAN COVERAGE	**Ambulance** ***(per one way trip)***	$125 Copay	$150 Copay	$125 Copay
		Durable Medical Equipment ***(including oxygen)***	20% Coinsurance	20% Coinsurance	20% Coinsurance
DRUG	PART D DRUGS (UP TO 31 DAYS)	**Initial Coverage**	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty
		Coverage Gap	Generics (58% coins) Brand (45% coins including 50% discount)	Generics (58% coins) Brand (45% coins including 50% discount)	Generics: Tier 1 ($3) Generics: Tier 2 ($15) Generics Tiers 3-5 (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs ***(up to 90 day supply; specialty tier up to 31 days supply)***	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty

PENDING CMS APPROVAL

SW Counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland
WC Counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, Warren

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HIGHMARK. MEDICARE SOLUTIONS

Freedom Blue PPO (Central and Northeastern Pennsylvania)

			Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
HEALTH	BASIC PLAN COSTS	**Monthly Plan Premium**	$64	$59	$174	$279
		Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000
		Out-of-Network	30% OON Coinsurance	30% OON Coinsurance	30% OON Coinsurance	30% OON Coinsurance
	PHYSICIAN SERVICES	**Doctor Office Visit**	$15 IN; $30 OON	$15 IN; $30 OON	$10 IN; $30 OON	$5 IN; $30 OON
		Specialist Office Visit	$35 IN; $45 OON	$40 IN; $50 OON	$35 IN; $45 OON	$30 IN; $40 OON
		Lab & Diagnostic Test	Office/Lab: $5 Copay Outpatient: $15 Copay	Office/Lab: $5 Copay Outpatient: $15 Copay	Office/Lab: $0 Copay Outpatient: $10 Copay	Covered in Full
		X-rays/Advanced Imaging	$30 X-Ray/$125 Advanced Imaging	$30 X-Ray/$150 Advanced Imaging	$20 X-Ray/$75 Advanced Imaging	$10 X-Ray/$50 Advanced Imaging
		Preventative Testings & Screenings	Covered In Full	Covered In Full	Covered In Full	Covered In Full
	FACILITY SERVICES	**Outpatient Surgery**	ASC: $100 Copay Facility: $200 Copay	ASC: $200 Copay Facility: $300 Copay	ASC: $150 Copay Facility: $250 Copay	ASC: $100 Copay Facility: $200 Copay
		Emergency Room	$75 Copay	$75 Copay	$75 Copay	$75 Copay
		Inpatient Hospital Stay	$350/admit	$250/day (days 1-5)/admit	$500/admit	$250/admit
		Skilled Nursing Facility ***(days 1-100 per benefit period per admit)***	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)
	ADDITIONAL BENEFITS	**Routine Vision** ***(annually)***	$0 Copay for routine eye exam. 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. $200 benefit maximum for post cataract eyewear.			
		Routine Hearing ***(2 hearing aids per year)***	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $499 copay per aid TruHearing Chime 900: $799 copay per aid
		Routine Dental	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $20 Copay (1 every calendar year) X-Ray: $20 Copay (1 every calendar year)
		Routine Chiropractic	$20 Copay (8 visits)	$20 Copay (8 visits)	$20 Copay (8 visits)	$20 Copay (8 visits)
		Routine Podiatry	$35 Copay (10 visits)	$40 Copay (10 visits)	$35 Copay (10 visits)	$30 Copay (10 visits)
	OTHER PLAN COVERAGE	**Ambulance** ***(per one way trip)***	$125 Copay	$150 Copay	$125 Copay	$100 Copay
		Durable Medical Equipment ***(including oxygen)***	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
DRUG	PART D DRUGS (UP TO 31 DAYS)	**Initial Coverage**	Not Covered	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty
		Coverage Gap	Not Covered	Generics (58% coins) Brand (45% coins including 50% discount)	Generics (58% coins) Brand (45% coins including 50% discount)	Generics: Tier 1 ($3) Generics: Tier 2 ($15) Generics Tiers 3-5 (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage	Not Covered	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs ***(up to 90 day supply; specialty tier up to 31 days supply)***	Not Covered	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty

PENDING CMS APPROVAL

Central Counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York

NEPA Counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, Wyoming

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HIGHMARK. MEDICARE SOLUTIONS

Freedom Blue PPO (West Virginia)

			Freedom Blue PPO ValueRx	Freedom Blue PPO Standard
HEALTH	BASIC PLAN COSTS	**Monthly Plan Premium**	$75	$212
		Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000
		Out-of-Network	30% OON Coinsurance	30% OON Coinsurance
	PHYSICIAN SERVICES	**Doctor Office Visit**	$15 IN; $30 OON	$10 IN; $30 OON
		Specialist Office Visit	$40 IN; $50 OON	$35 IN; $45 OON
		Lab & Diagnostic Test	Office/Lab: $5 Copay Outpatient: $15 Copay	Office/Lab: $0 Copay Outpatient: $10 Copay
		X-rays/Advanced Imaging	$25 X-Ray/$200 Advanced Imaging	$25 X-Ray/$100 Advanced Imaging
		Preventative Testings & Screenings	Covered In Full	Covered In Full
	FACILITY SERVICES	**Outpatient Surgery**	ASC: $250 Copay Facility: $350 Copay	ASC: $100 Copay Facility: $200 Copay
		Emergency Room	$75 Copay	$75 Copay
		Inpatient Hospital Stay	$300/day (days 1-5)/admit	$150/day (days 1-7)/admit
		Skilled Nursing Facility ***(days 1-100 per benefit period per admit)***	$0/day (days 1-20); $160/day (days 21-100)	$0/day (days 1-20); $160/day (days 21-100)
	ADDITIONAL BENEFITS	**Routine Vision** ***(annually)***	$0 Copay for routine eye exam. 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. $200 benefit maximum for post cataract eyewear.	
		Routine Hearing ***(2 hearing aids per year)***	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid	TruHearing Chime 500: $699 copay per aid TruHearing Chime 900: $999 copay per aid
		Routine Dental	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)	Office Visit: $30 Copay (1 every calendar year) X-Ray: $25 Copay (1 every calendar year)
		Routine Chiropractic	$20 Copay (8 visits)	$20 Copay (8 visits)
		Routine Podiatry	$40 Copay (10 visits)	$35 Copay (10 visits)
	OTHER PLAN COVERAGE	**Ambulance** ***(per one way trip)***	$200 Copay	$175 Copay
		Durable Medical Equipment ***(including oxygen)***	20% coinsurance	20% coinsurance
DRUG	PART D DRUGS (UP TO 31 DAYS)	**Initial Coverage**	$3 Pref. Gen, $15 Non-Pref. Gen, $47 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$3 Pref. Gen, $15 Non-Pref. Gen, $44 Pref. Brand, 45% Non-Pref Brand, 33% Specialty
		Coverage Gap	Generics (58% coins) Brand (45% coins including 50% discount)	Generics (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs ***(up to 90 day supply; specialty tier up to 31 days supply)***	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $117.50 Pref. Brand, 45% Non-Pref Brand, 33% Specialty	$7.50 Pref. Gen, $37.50 Non-Pref. Gen, $110 Pref. Brand, 45% Non-Pref Brand, 33% Specialty

PENDING CMS APPROVAL

WV Counties: Barbour, Berkeley, Brooke, Cabell, Doddridge, Fayette, Greenbrier, Hampshire, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Marion, Mason, Mercer, Mingo, Monongalia, Nicholas, Ohio, Pendleton, Putnam, Ritchie, Summers, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt, Wood, Wyoming

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HIGHMARK® MEDICARE SOLUTIONS

Blue Rx PDP (PA and WV)

			Blue Rx PDP Plus	Blue Rx PDP Complete
DRUG	BASIC PLAN COSTS	Monthly Plan Premium	$81.20	$149.20
		Annual Deductible	$360	$0
	PART D DRUGS (UP TO 31 DAYS)	**Retail Pharmacy (up to 31 day supply)**		
		Initial Coverage (up to $3,310 in total Rx costs)	$0 Pref. Gen, $11 Non-Pref. Gen, 25% Pref. Brand, 50% Non-Pref Brand, 25% Specialty	$2 Pref. Gen, $12 Non-Pref. Gen, $47 Pref. Brand, 50% Non-Pref Brand, 33% Specialty
		Coverage Gap (from $3,310 in total Rx costs to $4,850 Member OOP)	Generics (58% coins) Brand (45% coins including 50% discount)	Generics: Tier 1 ($38%) Generics: Tier 2 ($38%) Generics Tiers 3-5 (58% coins) Brand (45% coins including 50% discount)
		Catastrophic Coverage (from $4,850 Member OOP)	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others	Greater of: 5% or $2.95 Gen/Pref. Multi Source or $7.40 for all others
		Mail Order Drugs (up to 90 day supply)		
		Mail Order Drugs (initial coverage period)	$0 Pref. Gen, $27.50 Non-Pref. Gen, 25% Pref. Brand, 50% Non-Pref Brand, 25% Specialty	$5 Pref. Gen, $30 Non-Pref. Gen, $117.50 Pref. Brand, 50% Non-Pref Brand, 33% Specialty

Blue Rx PDP Regions:

All of Pennsylvania and West Virginia

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