

# Benefits for the whole you.

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## 2023 Summary of Benefits

January 1, 2023 – December 31, 2023

Highmark Wholecare  
Medicare Assured Diamond<sup>SM</sup> (HMO SNP)

Highmark Wholecare  
Medicare Assured Ruby<sup>SM</sup> (HMO SNP)

This section is a summary of benefits. It doesn't list every service, limitation, or exclusion. To get a full view of benefits, go to [HighmarkWholecare.com](https://www.HighmarkWholecare.com) where you can view the Evidence of Coverage.

Questions? Call us at **1-877-428-3929 (TTY 711)**.

Our hours of operation are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31.

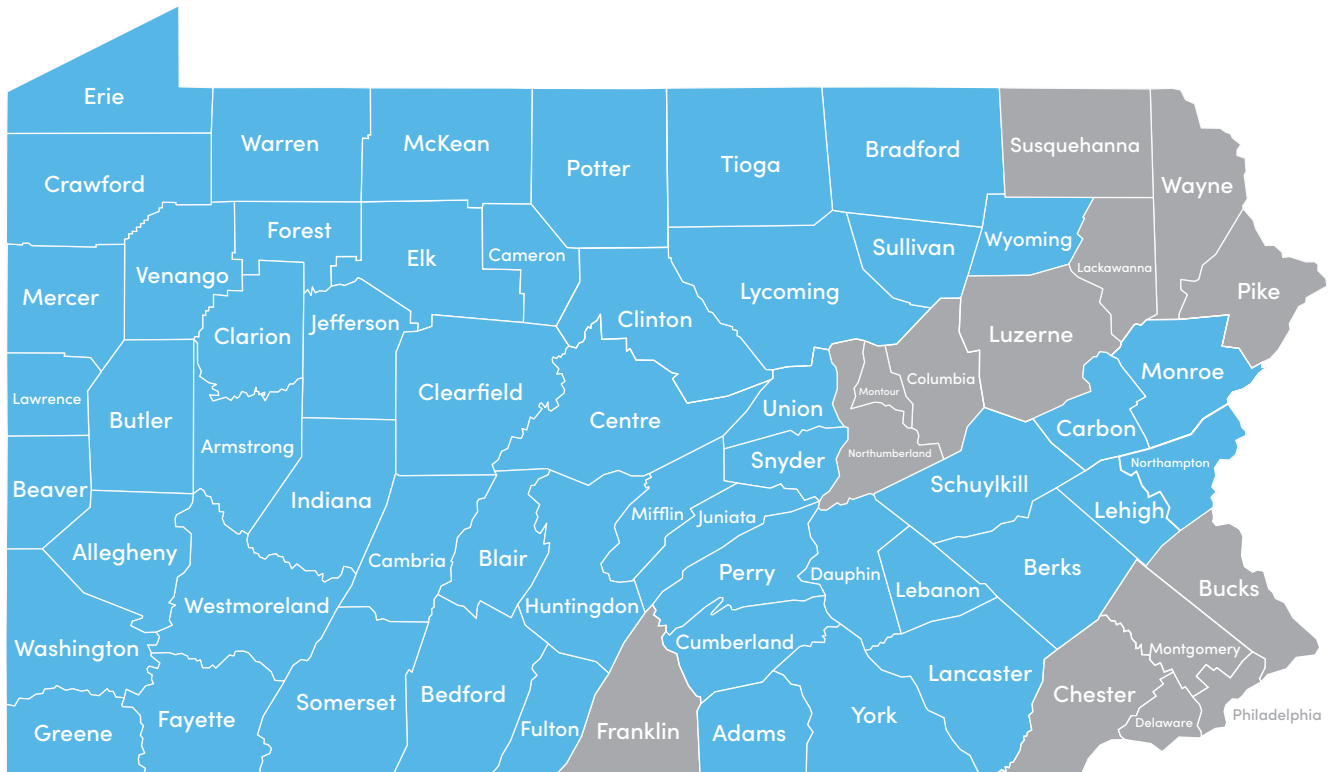
From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m.



Highmark Wholecare offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

# Pennsylvania Service Area

To enroll in our plans, you must live in one of the 53 Pennsylvania counties listed below.



- Adams
- Allegheny
- Armstrong
- Beaver
- Bedford
- Berks
- Blair
- Bradford
- Butler
- Cambria
- Cameron
- Carbon
- Centre
- Clarion
- Clearfield
- Clinton
- Crawford
- Cumberland
- Dauphin
- Elk
- Erie
- Fayette
- Forest
- Fulton
- Greene
- Huntingdon
- Indiana
- Jefferson
- Juniata
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- Lycoming
- McKean
- Mercer
- Mifflin
- Monroe
- Northampton
- Perry
- Potter
- Schuylkill
- Snyder
- Somerset
- Sullivan
- Tioga
- Union
- Venango
- Warren
- Washington
- Westmoreland
- Wyoming
- York

Please note that while you are required to live in one of the 53 Pennsylvania counties within the service area, you may continue to see participating providers in those 53 counties as well as the following additional 5 counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

# Highmark Wholecare Medicare Advantage Plans

## Dual Eligible Special Needs Plan (DSNP) Highlights

|                                                                                                                                                                                                                                                                                                                                                                                          | Highmark Wholecare Medicare Assured Diamond (HMO SNP) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Monthly Plan Premium                                                                                                                                                                                                                                                                                                                                                                     | \$0                                                   |
| Primary Care Visits                                                                                                                                                                                                                                                                                                                                                                      | \$0                                                   |
| Deductible                                                                                                                                                                                                                                                                                                                                                                               | \$0                                                   |
| Preventive Care                                                                                                                                                                                                                                                                                                                                                                          | \$0                                                   |
| Urgent & Emergency Care                                                                                                                                                                                                                                                                                                                                                                  | In- and out-of-network                                |
| Diagnostic Services/ Labs/Imaging                                                                                                                                                                                                                                                                                                                                                        | \$0                                                   |
| Prescriptions                                                                                                                                                                                                                                                                                                                                                                            | \$0                                                   |
| <b>ELIGIBILITY REQUIREMENTS:</b> <ul style="list-style-type: none"><li>• Must have Medicare Parts A and B</li><li>• Must be enrolled in one of the following Medicare Savings Programs offered by Medicaid for individuals with limited income and resources<ul style="list-style-type: none"><li>- FDBE, QMB+, SLMB+, or QMB</li></ul></li><li>• Live within our service area</li></ul> |                                                       |

|                                                                                                                                                                                                                                                                                                                                                                           | Highmark Wholecare Medicare Assured Ruby (HMO SNP) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| Monthly Plan Premium                                                                                                                                                                                                                                                                                                                                                      | \$0                                                |
| Primary Care Visits                                                                                                                                                                                                                                                                                                                                                       | \$0                                                |
| Deductible                                                                                                                                                                                                                                                                                                                                                                | \$0                                                |
| Preventive Care                                                                                                                                                                                                                                                                                                                                                           | \$0                                                |
| Urgent & Emergency Care                                                                                                                                                                                                                                                                                                                                                   | In- and out-of-network                             |
| Diagnostic Services/ Labs/Imaging                                                                                                                                                                                                                                                                                                                                         | As low as \$0                                      |
| Prescriptions                                                                                                                                                                                                                                                                                                                                                             | \$0                                                |
| <b>ELIGIBILITY REQUIREMENTS:</b> <ul style="list-style-type: none"><li>• Must have Medicare Parts A and B</li><li>• Must be enrolled in one of the following Medicare Savings Programs offered by Medicaid for individuals with limited income and resources<ul style="list-style-type: none"><li>- SLMB or QI</li></ul></li><li>• Live within our service area</li></ul> |                                                    |

### MEDICARE SAVINGS PROGRAMS DEFINITIONS:

**(FDBE) Full Benefit Dual Eligible:** An individual is medically needy or in certain special income levels for institutionalized or home- and community-based waivers.

**(QMB+) Qualified Medicare Beneficiary Plus:** Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). People with QMB+ also have "full Medicaid benefits."

**(QMB) Qualified Medicare Beneficiary:** Helps pay Medicare Part A and Part B premiums and other cost-sharing like deductibles, coinsurance, and copayments.

**(SLMB+) Specified Low-Income Medicare Beneficiary Plus:** Helps pay Part B premium, as well as all "full Medicaid benefits."

**(SLMB) Specified Low-Income Medicare Beneficiary:** Helps pay Part B premium.

**(QI) Qualifying Individual:** Helps pay Part B premium but is limited to a first-come, first-served basis.

| Premiums and Benefits                                                      | Highmark Wholecare Medicare Assured Diamond (HMO SNP)                                                                      | Highmark Wholecare Medicare Assured Ruby (HMO SNP)                                                                                                               |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly Plan Premium                                                       | You pay \$0.                                                                                                               | You pay \$0.                                                                                                                                                     |
| Deductible                                                                 | No deductible.                                                                                                             | No deductible.                                                                                                                                                   |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | You pay no more than \$8,300 annually for in-network Medicare-covered services.                                            | You pay no more than \$6,700 annually for in-network Medicare-covered services.                                                                                  |
| Inpatient Hospital <sup>^</sup>                                            | You pay per benefit period a:<br>\$0 copay each day for days 1-90.<br>\$0 copay each day for lifetime reserve days 91-150. | You pay per benefit period a:<br>\$250 copay each day for days 1-6.<br>\$0 copay each day for days 7-90.<br>\$0 copay each day for lifetime reserve days 91-150. |
| Outpatient Hospital <sup>^</sup>                                           | You pay \$0 copay for each Medicare-covered outpatient service.                                                            | Depending on the service provided, you pay between \$0 copay and 20% coinsurance.                                                                                |
| Ambulatory Surgery Center                                                  | You pay \$0 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.                    | You pay \$200 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.                                                        |
| Doctor Visits                                                              |                                                                                                                            |                                                                                                                                                                  |
| • Primary Care                                                             | You pay \$0 copay for each primary care physician visit.                                                                   | You pay \$0 copay for each primary care physician visit.                                                                                                         |
| • Specialists                                                              | You pay \$0 copay for each specialist physician visit.                                                                     | You pay \$25 copay for each specialist physician visit.                                                                                                          |
| Preventive Care (e.g., flu vaccine, cancer screenings)                     | You pay \$0.                                                                                                               | You pay \$0.                                                                                                                                                     |
| Emergency Care                                                             | You pay \$0 copay for each emergency care service.                                                                         | You pay \$95 copay for each emergency care service.<br>Copay is waived if admitted to hospital within 24 hours.                                                  |
| Urgently Needed Services                                                   | You pay \$0 copay for each urgently needed service.                                                                        | You pay \$25 copay for each urgently needed service.                                                                                                             |

<sup>^</sup>Prior authorization may be required

| Premiums and Benefits                                                                                                                                                                         | Highmark Wholecare Medicare Assured Diamond (HMO SNP)                                                                                                                                                                                                                                                                                                                                                            | Highmark Wholecare Medicare Assured Ruby (HMO SNP)                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic Services/<br/>Labs/Imaging<sup>^</sup></b> <ul style="list-style-type: none"> <li>Diagnostic tests and procedures/lab services</li> <li>MRI, CT scan</li> <li>X-rays</li> </ul> | <p>You pay \$0 copay for each Medicare-covered lab service and diagnostic procedure/test.</p> <p>You pay \$0 copay for each Medicare-covered Advanced Imaging service.</p> <p>You pay \$0 copay for each Medicare-covered x-ray service.</p>                                                                                                                                                                     | <p>You pay \$0 copay for each Medicare-covered lab service and diagnostic procedure/test.</p> <p>You pay \$175 copay for each Medicare-covered Advanced Imaging service.</p> <p>You pay \$35 copay for each Medicare-covered x-ray service.</p>                                                                                                                                                              |
| <b>Hearing Services</b> <ul style="list-style-type: none"> <li>Routine hearing exam</li> <li>Hearing aid allowance</li> </ul>                                                                 | <p>You pay \$0 copay for 1 routine hearing exam per year.</p> <p>You pay \$0 copay for one hearing aid per ear every year. Rechargeable model now available.</p>                                                                                                                                                                                                                                                 | <p>You pay \$0 copay for 1 routine hearing exam per year.</p> <p>You pay \$0 copay for one hearing aid per ear every three years. Rechargeable model now available.</p>                                                                                                                                                                                                                                      |
| <b>Dental Services</b> <ul style="list-style-type: none"> <li>Preventive dental services</li> <li>Comprehensive dental services</li> <li>Dentures</li> <li>Annual allowance</li> </ul>        | <p>You pay \$0 for one cleaning, one oral exam, one x-ray every six months, and one panoramic x-ray every five years.</p> <p>You pay \$0 for fillings, simple extractions, two root canals, two crowns, and periodontal maintenance every year.</p> <p>You pay \$0 for dentures every year (applies to the annual allowance).</p> <p>\$8,000 allowance for comprehensive and preventive services every year.</p> | <p>You pay \$0 for one cleaning, one oral exam, one x-ray every six months, and one panoramic x-ray every five years.</p> <p>You pay \$0 for fillings, simple extractions, one root canal, one crown, and periodontal maintenance every year.</p> <p>You pay \$0 for dentures every five years (does not apply to the annual allowance).</p> <p>\$3,500 allowance for comprehensive services every year.</p> |

<sup>^</sup>Prior authorization may be required

| Premiums and Benefits                                                                                                              | Highmark Wholecare Medicare Assured Diamond (HMO SNP)                                                                                                                                                                                                                                                                                           | Highmark Wholecare Medicare Assured Ruby (HMO SNP)                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Vision Services</b> <ul style="list-style-type: none"> <li>Routine eye exam</li> <li>Eyewear</li> </ul>                         | <p>You pay \$0 copay for one routine eye exam per calendar year.</p> <p>You pay \$0 for standard lenses and frames from the vendor collection or standard contacts, or you will have a \$600 allowance towards the purchase of non-vendor frames or contact lenses. Limited lens upgrades available for \$0 copay. Plan restrictions apply.</p> | <p>You pay \$0 copay for one routine eye exam per calendar year.</p> <p>You pay \$0 for standard lenses and frames from the vendor collection or standard contacts, or you will have a \$200 allowance towards the purchase of non-vendor frames or contact lenses. Plan restrictions apply.</p> |
| <b>Mental Health Services</b> <ul style="list-style-type: none"> <li>Outpatient group therapy/individual therapy visit</li> </ul>  | <p>You pay \$0 copay for each Medicare-covered mental health visit.</p>                                                                                                                                                                                                                                                                         | <p>You pay \$25 copay for each Medicare-covered mental health visit.</p>                                                                                                                                                                                                                         |
| <b>Skilled Nursing Facility</b> <sup>^</sup>                                                                                       | <p>You pay \$0 copay per day for days 1-100.</p>                                                                                                                                                                                                                                                                                                | <p>You pay \$0 copay per day for days 1-20. \$196 copay per day for days 21-100.</p>                                                                                                                                                                                                             |
| <b>Outpatient Therapy</b> <sup>^</sup> <ul style="list-style-type: none"> <li>Physical, Occupational and Speech Therapy</li> </ul> | <p>You pay \$0.</p>                                                                                                                                                                                                                                                                                                                             | <p>You pay \$20.</p>                                                                                                                                                                                                                                                                             |
| <b>Ambulance</b> <sup>^</sup>                                                                                                      | <p>You pay \$0 copay for ground and air ambulance services.</p>                                                                                                                                                                                                                                                                                 | <p>You pay \$250 copay for ground and air ambulance services.</p>                                                                                                                                                                                                                                |
| <b>Transportation</b>                                                                                                              | <p>You pay \$0 copay for routine transportation services. Routine transportation to plan-approved health-related locations is covered for up to 100 one-way trips per calendar year. Member has the option to use 24 of the 100 one-way trips for non-health related services.</p>                                                              | <p>You pay \$0 copay for routine transportation services. Routine transportation to plan-approved health-related locations is covered for up to 30 one-way trips per calendar year.</p>                                                                                                          |

<sup>^</sup>Prior authorization may be required

| Premiums and Benefits               | Highmark Wholecare Medicare Assured Diamond (HMO SNP)                                                                                                                                    | Highmark Wholecare Medicare Assured Ruby (HMO SNP)                                                                                                                                       |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Healthy Food Benefit                | You receive \$135 per month Healthy Food Benefit allowance. Unused amounts expire at the end of the month. Plan restrictions apply.                                                      | Not covered.                                                                                                                                                                             |
| Utility Support Benefit             | You receive \$100 per quarter to be used for plan-approved utility expenses. Unused amounts expire at the end of the quarter. Plan restrictions apply.                                   | Not covered.                                                                                                                                                                             |
| Medicare Part B Drugs <sup>^*</sup> | You pay \$0 copay for chemotherapy and other Part B prescription drugs.                                                                                                                  | You pay a 20% coinsurance of the total cost for chemotherapy and other Part B prescription drugs.                                                                                        |
| Over-the-Counter Allowance          | You pay \$0 copay for OTC items. \$320 allowance per quarter. Unused allowance amounts expire at the end of each quarter.                                                                | You pay \$0 copay for OTC items. \$140 allowance per quarter. Unused allowance amounts expire at the end of each quarter.                                                                |
| Home-Delivered Meals                | You pay \$0 copay for home-delivered meals. Limit of up to 28 meals (2 per day) for 14 days.                                                                                             | You pay \$0 copay for home-delivered meals. Limit of up to 14 meals (2 per day) for 7 days.                                                                                              |
| 24/7 Nurse Line                     | There is no coinsurance, copayment or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week. | There is no coinsurance, copayment or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week. |
| Home Safety Items                   | You pay \$0 copay for plan-approved home and bathroom safety devices. Limited to 6 Bathroom Safety devices per year.                                                                     | You pay \$0 copay for plan-approved home and bathroom safety devices. Limited to 2 Bathroom Safety devices per year.                                                                     |
| Personal Emergency Response System  | You pay \$0 copay for one personal emergency response system device per lifetime.                                                                                                        | You pay \$0 copay for one personal emergency response system device per lifetime.                                                                                                        |
| Fitness Benefit                     | Provides membership at participating SilverSneakers fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.                                    | Provides membership at participating SilverSneakers fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.                                    |

<sup>^</sup>Prior authorization may be required

<sup>\*</sup>Certain rebatable drugs may be subject to a lower coinsurance. After 7/1/2023, Insulin cost sharing is subject to a coinsurance cap of \$35 for a one-month's supply of insulin.

| Premiums and Benefits                            | Highmark Wholecare Medicare Assured Diamond (HMO SNP) | Highmark Wholecare Medicare Assured Ruby (HMO SNP) |
|--------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|
| <b>Outpatient Prescription Drugs<sup>^</sup></b> |                                                       |                                                    |
| <b>Part D Deductible</b>                         | You pay \$0.                                          | You pay \$0.                                       |
| <b>Initial Coverage Stage</b>                    |                                                       |                                                    |
| Tier 1: Preferred Generic                        | You pay \$0 per prescription.                         | You pay \$0 per prescription.                      |
| Tier 2: Generic                                  | You pay \$0 per prescription.                         | You pay \$0 per prescription.                      |
| Tier 3: Preferred Brand                          | You pay \$0 per prescription.                         | You pay \$0 per prescription.                      |
| Tier 4: Non-Preferred                            | You pay \$0 per prescription.                         | You pay \$0 per prescription.                      |
| Tier 5: Specialty                                | You pay \$0 per prescription.                         | You pay \$0 per prescription.                      |
| <b>Coverage Gap Stage</b>                        | You pay \$0 per prescription in all tiers.            | You pay \$0 per prescription in all tiers.         |
| <b>Catastrophic Coverage Stage</b>               | You pay \$0 per prescription in all tiers.            | You pay \$0 per prescription in all tiers.         |

If you want to know more about the cost and coverage of Original Medicare, look in your current “Medicare & You” handbook. You can 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, seven days a week. (TTY **1-877-486-2048**)

<sup>^</sup>Prior authorization may be required

SilverSneakers is a registered trademark of Tivity, Inc. Tivity, Inc. is a separate company that administers the SilverSneakers Fitness Program.

# Summary of Medicaid-covered benefits.

The benefits described below are covered by Medicaid. Your services are paid first by your Medicare plan, and then by Medicaid. If a benefit is used up or not covered by Medicare, then Medicaid may provide coverage.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Pennsylvania Department of Human Services, **1-800-692-7462** (TTY users call **1-800-451-5886**), or visit their website at **[www.dhs.pa.gov](http://www.dhs.pa.gov)**.

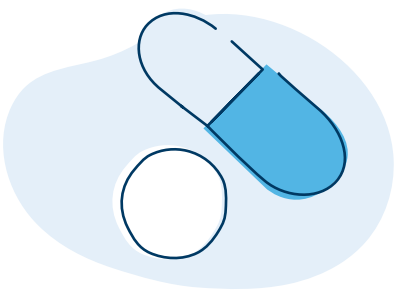
| Benefits                                               | What you pay under Medicaid.                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital Coverage</b>                     | \$3 copay per day up to \$21 per admission<br>Includes general hospitals, rehabilitation hospitals, drug and alcohol and private psychiatric hospitals                                                                                                                                                                                                             |
| <b>Doctor Visits</b><br>(Primary Care and Specialists) | \$0-\$3.80 copay for Medicaid-covered services<br>Physician (Medical Doctor), Certified Registered Nurse Practitioner and Rural Health Clinic                                                                                                                                                                                                                      |
| <b>Emergency Care</b>                                  | \$0 copay for Emergency Services                                                                                                                                                                                                                                                                                                                                   |
| <b>Urgently Needed Services</b>                        | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                                                                                     |
| <b>Diagnostic Services/ Labs/ Imaging</b>              | \$0 copay (laboratory); \$1 copay (portable x-ray)<br>\$1 copay for each x-ray or \$0 for other medical diagnostic test or for treatment by nuclear medicine or radiation therapy                                                                                                                                                                                  |
| <b>Dental Services</b>                                 | \$0-\$3.80 copay for Medicaid-covered services <ul style="list-style-type: none"><li>Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics, and sedation</li><li>Key Limitations: Dentures: 1 per lifetime; Exams/prophylaxis: 1 per 180 days; Crowns, periodontics and endodontics: only via approved benefit limit exception</li></ul> |
| <b>Vision Services</b>                                 | \$0-\$3.80 copay for Medicaid-covered services <ul style="list-style-type: none"><li>Optometrist (Eye Doctor)</li><li>2 exams per calendar year</li><li>Eyeglass lenses, frames and contact lenses are limited to individuals with aphakia; 4 eyeglass lenses per calendar year; 2 eyeglass frames per calendar year; and 4 contact lenses per calendar</li></ul>  |
| <b>Skilled Nursing Facility (SNF)</b>                  | \$0-\$3.80 copay for Medicaid-covered services<br>Nursing Facilities                                                                                                                                                                                                                                                                                               |
| <b>Ambulance (Emergency)</b>                           | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                                                                                     |
| <b>Transportation</b>                                  | \$0 copay for Medicaid-covered services<br>Contact Medical Assistance Transportation (MATP) for information                                                                                                                                                                                                                                                        |
| <b>Foot Care</b>                                       | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                                                                                     |
| <b>Medical Equipment/Supplies</b>                      | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                                                                                     |

| Benefits                                            | What you pay under Medicaid.                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prescription Drugs</b>                           | \$1-\$3 copay for Medicaid-covered prescriptions <ul style="list-style-type: none"> <li>• \$1 for each prescription and prescription refill of a generic drug</li> <li>• \$3 for each prescription and prescription refill of a brand name drug</li> <li>• Nutritional supplements</li> </ul> |
| <b>Outpatient Surgery</b>                           | \$0-\$3.80 copay for Medicaid-covered services<br>Ambulatory Surgery Center (ASC) and Same Day Surgery (SPU); Independent Medical/Surgical Clinic                                                                                                                                             |
| <b>Chiropractic Care</b>                            | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                |
| <b>Drug and Alcohol Clinic Services</b>             | \$0-\$3.80 copay for Medicaid-covered services <ul style="list-style-type: none"> <li>• Includes methadone maintenance and clozapine</li> <li>• Refer to your Behavioral Health Managed Care Organization for details</li> </ul>                                                              |
| <b>Psychiatric Clinic</b>                           | \$0.50 per unit copay for Medicaid-covered services <ul style="list-style-type: none"> <li>• Includes mobile mental health treatment</li> <li>• Refer to your Behavioral Health Managed Care Organization for details</li> </ul>                                                              |
| <b>Psychiatric Partial Hospitalization Facility</b> | \$0 per unit copay for Medicaid-covered services<br>Refer to your Behavioral Health Managed Care Organization for details                                                                                                                                                                     |
| <b>Psychiatric Rehabilitation</b>                   | \$0-\$3.80 copay for Medicaid-covered services<br>Refer to your Behavioral Health Managed Care Organization for details                                                                                                                                                                       |
| <b>Federally Qualified Health Center</b>            | \$0-\$3.80 copay for Medicaid-covered services                                                                                                                                                                                                                                                |
| <b>Home Health Services</b>                         | \$0 copay for Medicaid-covered services<br>Includes nursing, aide, and therapy services. Unlimited for the first 28 days; limited to 15 days every month thereafter                                                                                                                           |
| <b>Hospice Care</b>                                 | \$0-\$3.80 copay for Medicaid-covered services<br>Respite care may not exceed a total of 5 days in a 60-day certification period                                                                                                                                                              |
| <b>Long-Term Nursing Facility</b>                   | \$0-\$3.80 copay for Medicaid-covered services<br>In order to receive Long-term Nursing Facility or Home and Community-Based Waiver Services, individuals must meet clinical criteria to be considered Nursing Facility Clinically Eligible (NFCE)                                            |
| <b>Home and Community Based Waiver Services</b>     | \$0 copay for Medicaid-covered services<br>For more information, contact your Community HealthChoices MCO or the Office of Long-term Living                                                                                                                                                   |
| <b>Renal Dialysis</b>                               | \$0-\$3.80 copay for Medicaid-covered services<br>Renal dialysis center; initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility are limited to 75 per calendar year.                                                       |
| <b>Therapy (Physical, Occupational, Speech)</b>     | \$0-\$3.80 copay for Medicaid-covered services<br>Only when provided by a hospital, outpatient clinic, or home health provider                                                                                                                                                                |
| <b>Prosthetics and Orthotics</b>                    | \$0-\$3.80 copay for Medicaid-covered services<br>Orthopedic shoes and hearing aids are not covered. Coverage for low-vision aids is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.                                                         |

# Important information for those receiving Extra Help.

Highmark Wholecare  
Medicare Assured Diamond<sup>SM</sup>

Highmark Wholecare  
Medicare Assured Ruby<sup>SM</sup>



## Monthly plan premium for people who get Extra Help from Medicare to help pay for their prescription drug costs.

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare. The amount of Extra Help you get will determine your total monthly plan premium as a member of our plan.

This table shows you what your monthly plan premium will be if you get Extra Help.

| Your level of Extra Help | Highmark Wholecare Medicare Assured Diamond (HMO SNP) | Highmark Wholecare Medicare Assured Ruby (HMO SNP) |
|--------------------------|-------------------------------------------------------|----------------------------------------------------|
| 100%                     | \$0                                                   | \$0                                                |
| 75%                      | Does not apply                                        | Does not apply                                     |
| 50%                      | Does not apply                                        | Does not apply                                     |
| 25%                      | Does not apply                                        | Does not apply                                     |

The amounts above do not include any Medicare Part B premium you may have to pay.

Highmark Wholecare Medicare Assured Diamond and Highmark Wholecare Medicare Assured Ruby premiums include coverage for both medical services and prescription drug coverage.

If you aren't getting Extra Help, you can see if you qualify by calling one of the following:

- 1-800-Medicare (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- Pennsylvania Medical Assistance (Medicaid) at 1-800-692-7462 between 8:30 a.m. and 4:45 p.m., Monday through Friday. TTY users should call 1-800-451-5886 or 711.
- Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

# Enrollment information you need.

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## Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-877-428-3929 (TTY 711)**.

### Understanding the benefits:

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [HighmarkWholesale.com](https://www.HighmarkWholesale.com) or call **1-877-428-3929 (TTY 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding important rules:

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. Depending on your level of Extra Help, part or all of this premium could be paid by Medicare. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You can also apply for Extra Help online at [www.socialsecurity.gov/prescriptionhelp](https://www.socialsecurity.gov/prescriptionhelp).
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a Dual Eligible Special Needs Plan (DSNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and Medical Assistance from a state plan under Medicaid. Other restrictions may apply.

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Highmark Wholecare:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- o Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- o Qualified interpreters
- o Information written in other languages

If you need these services, contact Member Services at 1-800-685-5209, 8 a.m - 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m. – 8 p.m., Monday through Friday. TTY users should call 711.

If you believe that Highmark Wholecare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Appeals and Grievances

Attention: 1557 Coordinator

PO Box 22278

Pittsburgh, PA 15222

Phone: 1-844-207-0336

Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Appeals and Grievances is available to help you. Additional information can be found at <https://highmarkwholecare.com/nondiscrimination-notice>.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711)。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 1-800-685-5209 (TTY 711)。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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711) 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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711) 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 1-800-685-5209 (TTY 711). 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 مترجم فوري، بمساعدتك. هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية (1-800-685-5209 (TTY 711) ليس عليك سوى الاتصال بنا على

**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 1-800-685-5209 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711). 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 1-800-685-5209 (TTY 711). Ta usługa jest bezpłatna.

**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、1-800-685-5209 (TTY 711) 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。

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare").