

Northwestern Pennsylvania

Community Blue Medicare PPO

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Crawford, Erie, Forest, Lawrence, McKean, Mercer, Potter, Venango and Warren

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Community Blue Medicare PPO, call 1-844-785-1787 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

Western Pennsylvania

This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Community Blue Medicare PPO Signature (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-Of-Network Benefit

The Out-Of-Network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

Western Pennsylvania

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Part IB Premium Reduction 52 Deductible 50 Max Out-Of-Pocket \$6.500 IN; \$10.000 Catastrophic Inpatient Hospital Stay Str. Corpus Per Admit IN*; \$252 Copus Per Admit IN*; \$250 Copus Pix*; \$350 Copus Oon Outpatient Hospital Coverage ASC*; \$175 Copus Pix*; \$350 Copus Oon Preventive Screening Coverage Coverage In Full (Office visit Copus No.) Preventive Screening Coverage In Full (Office visit Copus No.) Emergency Room \$90 Copus IN/OON Urgently Needed Services \$50 Copus IN*; \$35 Copus Oon Services \$50 Copus IN*; \$35 Copus Oon Arasys Advanced Inaging Advanced Imaging: \$350 Copus Oon Advanced Imaging: \$350 Copus IN*; \$35 Copus Oon Advanced Imaging: \$350 Copus IN*; \$35 Copus Oon Medicare Covered: \$30 Copus IN*; \$35 Copus Oon Medicare Covered: \$30 Copus IN*; \$35 Copus Oon Medicare Covered: \$30 Copus IN*; \$30 Copus Oon Vision Services Medicare Covered: \$30 Copus IN*; \$30 Copus Oon Vision Services Medicare Covered: \$30 Copus IN*; \$30 Copus Oon Vision Services Medicare Covered: \$30 Copus IN*; \$30 Copus Oon Vision Services Medicare Covered: \$30 Copus IN*; \$30 Copus Oon	Premium	
Reduction \$2 Deductible \$0 Max Out-O'-Pocket \$6,500 IN; \$10,000 Catastrophic Inpatient Hospital Stay \$322 Copay Per Admit IN*; \$475 Copay Per Admit IN*; \$475 Copay Per Admit OON Outpatient Hospital ACC: \$178 Copay Per Admit OON Doctor Office Visit PEP: \$0 Copay IN; \$300 Copay OON Preventive/ Screening Covered in Full (Office visit Copay may apply) IN/OON Bringengency Room \$00 Copay IN/OON Burdend \$50 Copay IN/OON Burdend \$50 Copay IN/OON Lab & Diagnostic Tests Office-Lab: \$0 Copay IN*; \$35 Copay OON Aray: \$20 Copay IN*; \$35 Copay OON Advanced Imaging Advanced Imaging, \$250 Copay IN*; \$35 Copay OON Advanced Imaging, \$250 Copay IN*; \$35 Copay OON Medicare Covered: \$30 Copay IN; \$30 Copay OON Alary: \$30 Copay IN; \$30 Copay OON Medicare Covered: \$30 Copay IN; \$30 Copay OON Medicare Covered: \$30 Copay IN; \$30 Copay OON Alary: \$30 Copay IN; \$30 Copay OON Vision Services Medicare Covered: \$30 Copay IN; \$30 Copay OON Vision Services Medicare Covered: \$30 Copay IN; \$30 Copay OON Vision Services Inpatient \$		
Max Out-Of-Pocket \$6,500 IN; \$10,000 Caustrophic Inpatient Hospital Stay \$325 Copay Per Admit IN*; Outpatient Hospital ASC ¹ ; \$175 Copay IN*; \$350 Copay OON Poctor Office Visit Preventive/ Screening Covered in Full (Office visit Copay may apply) IN/OON Preventive/ Screening Covered in Full (Office visit Copay may apply) IN/OON Bernergency Reom \$90 Copay IN/OON Urgently Needed Services \$50 Copay IN/OON Lab & Diagnostic Test Office/Lab: \$0 Copay IN*; \$350 Copay OON Covered in Full (Office visit Copay may apply) IN/OON Office/Lab: \$0 Copay IN*; \$350 Copay OON Lab & Diagnostic Test Office/Lab: \$0 Copay IN*; \$350 Copay OON Realing Services Medicare Covered: \$30 Copay IN*; \$350 Copay OON Realing Services Medicare Covered: \$30 Copay IN*; \$350 Copay OON Potatal Services Medicare Covered: \$30 Copay IN*; \$350 Copay OON (1 Per Year). Turtlearing Premium: \$999 Copay; OON (1 Per Year). Potatal Services Medicare Covered: \$30 Copay IN*; \$30 Copay OON. Potatal Services Medicare Covered: \$30 Copay IN*; \$30 Copay OON. Potatal Services Medicare Covered: \$30 Copay IN*; \$30 Copay Co		
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Style Copay Per Admin OON	Max Out-Of-Pocket	•
Coverage Facility: \$250 Copay IN*; \$350 Copay OON Doctor Office Visit PCP: \$0 Copay IN; \$0 Copay OON Preventive/ Screening Covered in Full (Office visit Copay may apply) IN/OON Emergency Room 590 Copay IN/OON Urgently Needed \$50 Copay IN/OON Lab & Diagnostic Tests Office/Lab's 0C Copay IN*; \$35 Copay OON X-Rays/ Advanced Imaging: X-ray: \$20 Copay IN*; \$35 Copay OON Hearing Services Advanced Imaging: \$25 Copay IN*; \$30 Copay OON Hearing Services Mediciare Covered: \$30 Copay IN*; \$30 Copay OON. THHearing Advanced: \$50 Copay IN; \$30 Copay OON. Poputal Services Mediciare Covered: \$30 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Advanced Imaging: \$30 Copay IN; \$30 Copay OON. Acceptable Advanced: \$30 Copay IN; \$30 Copay OON. Poputal Services Mediciare Covered: \$30 Copay IN; \$30 Copay OON. Mediciare Covered: \$30 Copay IN; \$30 Copay OON. Mediciare Covered: \$30 Copay IN; \$30 Copay OON. Mental Health Services Impact a Sa Copay IN; \$30 Copay OON. Skilled Nursing Facility Copay IN; \$30 Copay	Inpatient Hospital Stay	1 · ·
Specialist: \$30 Copay IN; \$30 Copay GON		
Emergency Room \$90 Copay IN/OON Urgently Needed Services \$50 Copay IN/OON Lab & Diagnostic Tests Office/Lab: \$0 Copay IN*; \$35 Copay OON Outputient: \$25 Copay IN*; \$35 Copay OON X-Rays/ Advanced Imaging: \$252 Copay IN*; \$35 Copay OON Advanced Imaging: \$252 Copay IN*; \$35 Copay OON Hearing Services Medicare Covered: \$30 Copay IN; \$30 Copay OON (1 Per Year). Truthearing Advanced: \$90 Copay); Truthearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year) Dental Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. (1 Per Year). Truthearing Advanced: \$690 Copay IN; \$30 Copay OON. (1 Per Year). Truthearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance OON (1 Per Year). Comprehensive: \$0% Coinsurance only (1 Per Year). Sundard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum spplies to non-standard frames or a \$150 benefit maximum for post cataract eyewear (once per operated eye). Mental Health Services Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$30 Copay IN*;	Doctor Office Visit	
Urgenity Needed Services \$50 Copay IN/OON Lab & Diagnostic Tests Office/Lab: \$0 Copay IN*; \$35 Copay OON X-Rays/ Advanced Imaging X-ray: \$20 Copay IN*; \$35 Copay OON Advanced Imaging: \$250 Copay IN*; \$35 Copay OON X-ray: \$20 Copay IN*; \$35 Copay OON Hearing Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. (Per Year). TruHearing Advanced: \$699 Copay; TruHearing Permium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year) Dental Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. (Per Year). Aray: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Aray: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Aray: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Aray: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Aray: \$15 Copay IN; \$30 Copay OON. (Per Year). Aray: \$15 Copay IN; \$30 Copay OON. (Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum \$750 allowance IN/OON (Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for post cataract eyewar (none per operated eye). Outpatient: \$40 Copay IN*; \$60 Copay/day (days 4-90) Soor Copay/day Coinsurance OON Mental Health Services Soo Copay/day (days 1-3), \$0 Copay/day (days 4-90) Soor Copay Copay Copay Copay Cop	Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Services \$50 Copay IN/OON Lab & Diagnostic Tests Office/Lab: \$0 Copay IN*; \$35 Copay OON X-Rays/ Advanced Imaging: X-ray: \$20 Copay IN*; \$35 Copay OON Advanced Imaging: X-ray: \$20 Copay IN*; \$35 Copay OON Hearing Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. Poental Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. Poental Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Average: \$10 Copay IN; \$30 Copay OON. Office Visit: \$15 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$30 Copay OON. Poental Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$30 Copay OON. Mental Health Services Inpatient: \$425 Copay IN; \$30 Copay OON. Skilled Nursing Facility \$0 Copay/day (days 1-3), \$0 Copay/day (days 4-90) ON Outpatient: \$40 Copay IN*; \$60 Copay OON. Physical Therapy \$0 Copay IN*; \$50 Copay OON. Physical Therapy \$0 Copay IN*; \$50 Copay OON. <	Emergency Room	\$90 Copay IN/OON
Compensation Comp	•	\$50 Copay IN/OON
Imaging Advanced Imaging: \$250 Copay IN*; \$350 Copay OON. Hearing Services Medicare Covered: \$30 Copay IN; \$30 Copay OON. (1 Per Year).	Lab & Diagnostic Tests	
Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Advanced: \$699 Copay; (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year).	·	
Dental Services Offfice Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$750 allowance IN/OON (Per Year). Wedicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for post cataract eyewear (once per operated eye). Mental Health Services Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-20), \$184 Copay OON (0utpatient: \$40 Copay IN*; \$60 Copay OON (0utpatient: \$40 Copay IN*; \$60 Copay OON (0utpatient: \$40 Copay IN*; \$60 Copay OON (0utpatient: \$40 Copay IN*; \$50 Copay OON (0utpatient: \$40 Copay IN*; \$50 Copay OON (0utpatient: \$40 Copay IN*; \$50 Copay IN*; \$60 Coinsurance OON Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON Routine Podiatry 320 Copay IN; \$30 Copay OON (4 Visits Per Year) Durable Medical Equipment 20% Coinsurance IN*; 30% Coinsurance after satisfying a \$500 Deductible OON	Hearing Services	Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay;
Routine: \$0 Copay IN; \$50 Copay OON (I Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye). Mental Health Services Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-20), \$184 Copay OON Outpatient: \$40 Copay IN*; \$60 Copay OON Skilled Nursing Facility Physical Therapy \$30 Copay IN*; \$50 Copay OON Ambulance (per oneway trip) Emergent/Non-Emergent: \$275 Copay IN**; \$00 Copay IN**; \$00 Copay IN**; \$00 Copay IN**; \$00 Coinsurance OON Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON OTC \$25 Allowance Once Per Quarter IN/OON Routine Podiatry 20% Coinsurance IN*; 30% Coinsurance OON Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Dental Services	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year).
Mental Health Services\$500 Copay/day (days 1-3), \$0 Copay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$60 Copay OONSkilled Nursing Facility\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OONPhysical Therapy\$30 Copay IN*; \$50 Copay OONAmbulance (per one- way trip)Emergent/Non-Emergent: \$275 Copay IN**; Non-Emergent: 30% Coinsurance OONTransportation\$0 Copay IN*; 30% Coinsurance OONPart B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$25 Allowance Once Per Quarter IN/OONRoutine Podiatry\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OONFitness BenefitCovered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Vision Services	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year.
Physical Therapy \$30 Copay IN*; \$50 Copay OON Ambulance (per one- way trip) Non-Emergent: \$275 Copay IN**; way trip) Non-Emergent: \$275 Copay IN**; Non-Emergent: \$0% Coinsurance OON Transportation \$0 Copay IN*; 30% Coinsurance OON Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON OTC \$25 Allowance Once Per Quarter IN/OON Routine Podiatry \$30 Copay IN; \$30 Copay OON (4 Visits Per Year) Durable Medical Equipment Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Mental Health Services	\$500 Copay/day (days 1-3), \$0 Copay/day (days 4-90) OON
Ambulance (per one-way trip) Emergent/Non-Emergent: \$275 Copay IN**; Non-Emergent: 30% Coinsurance OON Transportation \$0 Copay IN*; 30% Coinsurance OON Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON OTC \$25 Allowance Once Per Quarter IN/OON Routine Podiatry \$30 Copay IN; \$30 Copay OON (4 Visits Per Year) Durable Medical Equipment Pitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Skilled Nursing Facility	
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Part B Drugs 20% Coinsurance IN*; 30% Coinsurance OON OTC \$25 Allowance Once Per Quarter IN/OON Routine Podiatry \$30 Copay IN; \$30 Copay OON (4 Visits Per Year) Durable Medical Equipment 20% Coinsurance IN*; 30% Coinsurance OON Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	"	
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Routine Podiatry \$30 Copay IN; \$30 Copay OON (4 Visits Per Year) Durable Medical Equipment 20% Coinsurance IN*; 30% Coinsurance OON Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
Durable Medical Equipment 20% Coinsurance IN*; 30% Coinsurance OON Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	OTC	\$25 Allowance Once Per Quarter IN/OON
Equipment 20% Coinsurance IN*; 30% Coinsurance OON Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	Routine Podiatry	\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)
Fitness Benefit Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON		20% Coinsurance IN*; 30% Coinsurance OON
Formulary Performance	Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
	Formulary	Performance

^{*}Indicates a service that requires prior authorization.

^{**}Indicates a service that requires prior authorization for non-emergent trips.

	Standard Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply
		Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay
		Tier 2 (Generic)	\$15 Copay	\$45 Copay
		Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
		Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply
		Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay
		Tier 2 (Generic)	Not Applicable	\$45 Copay
		Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Coverage	Preferred Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply
		Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
		Tier 2 (Generic)	\$5 Copay	\$15 Copay
		Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
		Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier T (Non Treferred Brug)	ψιου συμή	1 7
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
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	Preferred	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Mail	Tier 5 (Specialty Tier) Tier	33% of the cost 31 Day Supply	Not Applicable 90 Day Supply
	Mail Cost-	Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic)	33% of the cost 31 Day Supply Not Applicable	Not Applicable 90 Day Supply \$0 Copay
	Mail	Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic)	33% of the cost 31 Day Supply Not Applicable Not Applicable	Not Applicable 90 Day Supply \$0 Copay \$12 Copay
	Mail Cost-	Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Brand)	33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable	Not Applicable 90 Day Supply \$0 Copay \$12 Copay \$120 Copay
Coverage Gap	Mail Cost- Sharing The coverage reaches \$4,130 and 25% of the	Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Brand) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) gap begins after the yearly drug co. After you enter the coverage ga	33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost ost (including what our plan has pop, you pay 25% of the plan's cost drugs until your costs total \$6,550,	Not Applicable 90 Day Supply \$0 Copay \$12 Copay \$120 Copay \$275 Copay Not Applicable aid and what you have paid) for covered brand name drugs
Coverage Gap	Mail Cost- Sharing The coverage reaches \$4,130 and 25% of the coverage gap.	Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Brand) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) gap begins after the yearly drug co. After you enter the coverage gae plan's cost for covered generic co	33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost ost (including what our plan has part post of the plan's cost drugs until your costs total \$6,550, arage gap.	Not Applicable 90 Day Supply \$0 Copay \$12 Copay \$120 Copay \$275 Copay Not Applicable aid and what you have paid) for covered brand name drugs
Coverage Gap Catastrophic Coverage	Mail Cost- Sharing The coverage reaches \$4,130 and 25% of the coverage gap. Generics (25%) After your year.	Tier 5 (Specialty Tier) Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Brand) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) gap begins after the yearly drug conduction of the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the coverage gase plan's cost for covered generic of Not everyone will enter the greater of Not everyone will enter the Not everyone w	33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost ost (including what our plan has part post of the plan's cost drugs until your costs total \$6,550, arage gap.	Not Applicable 90 Day Supply \$0 Copay \$12 Copay \$120 Copay \$275 Copay Not Applicable aid and what you have paid) for covered brand name drugs, which is the end of the



Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Your health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Shield provides post-sale administrative communications for these companies.

Highmark Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

Out-of-network/non-contracted providers are under no obligation to treat Community Blue Medicare PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-844-785-1787 (TTY users may call 711) for more information.

SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program.

TruHearing is a registered trademark of TruHearing, Inc.