

#### SOUTHWESTERN PENNSYLVANIA

## **Complete Blue PPO**

# **Summary of Benefits**

January 1, 2022 to December 31, 2022

The service area for these plans includes the following counties:

Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Washington, Westmoreland

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 Complete Blue PPO, call 1-833-544-1060 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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# SOUTHWESTERN 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

Complete Blue 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."

# SOUTHWESTERN PENNSYLVANIA

Premium   \$25.00     Part B Premium   \$0.00     Part B Premium   \$0.00     Reduction   \$0     Deductible   \$0     Max Out-OF-Pocket   \$5.00 IN; \$10,000 Catastrophic     Inpatient Hospital   \$295 copay per admit IN*; \$395 copay per admit OON     Stay   Coverage   Facility; \$250 copay IN*; \$325 copay OON     Doctor Office Visit   PCP: \$0 copay IN; \$0 copay IN; \$0 copay OON     Specialist; \$25 copay IN; \$25 copay OON   Specialist; \$25 copay IN; \$25 copay OON     Preventive/Scenerol   Severice   \$30 copay IN; \$0 copay IN; \$0 copay OON     Preventive/Scenerol   Severice   \$30 copay IN*; \$35 copay OON     Outgatient Hospital   \$30 copay IN*; \$35 copay OON   \$30 copay IN*; \$35 copay OON     Services   Outgatient; \$25 copay IN*; \$35 copay OON   \$30 copay IN*; \$35 copay OON     Services   Outgatient; \$24 copay IN*; \$35 copay OON   \$30 copay IN*; \$35 copay OON     Services   Outgatient; \$24 copay IN*; \$35 copay OON   \$30 copay IN*; \$35 copay OON, \$30 colosarance OON, IP er Year), Turl/Fenrium, \$40+ colos \$50 copay; Turl/Fenrium, \$40+ colos \$50 copay; Turl/Fenrium, \$40+ colos \$50 copay IN*; \$35 copay OON, \$40+ colosarance OON, IP er Year), \$50 copay ODN, \$10+ colosarance OON (IP er Year), \$				
Pat B Premium ReductionS0.00Net out-Of-PocketS0Out-Of-PocketS0.00 Ni, \$10,000 CatastrophicInpatient Hospital StayS295 copay per admit IN*; \$395 copay op admit ON S295 copay per admit IN*; \$395 copay ON S200 copay IN*; \$325 copay ON S200 copay IN*; \$200 copay IN*; \$325 copay ON S200 copay INV. \$25 copay ON S200 copay INV. \$25 copay ON S200 copay INVONPreventive/ScreeningCovered in Full (Office visit copay may apply) IN/OONPreventive/ScreeningCovered in Full (Office visit copay may apply) IN/OONPreventive/ScreeningCovered in Full (Office visit copay may apply) IN/OONPreventive/ScreeningCovered in Full (Office visit copay may apply) IN/OONVignetly NedgenS30 copay IN/ONUrgently NedgenS30 copay IN/ONVignetly AdvancedS30 copay IN*; \$35 copay OON Outpatient: \$25 copay IN*; \$35 copay OON Advanced Imaging: \$22 copay IN*; \$35 copay OON Routine: \$25 copay IN*; \$35 copay OON Routine: \$25 copay IN*; \$35 copay OON Routine: \$25 copay IN; \$35 copay OON Routine: \$25 copay IN; \$35 copay OON Routine: \$25 copay IN; \$35 copay OON. Routine: \$0 copay IN; \$35 copay OON. Routine: \$30 copay IN; \$35 copay OON. Routine: \$30 copay IN; \$35 co		Complete Blue PPO Distinct		
Reduction   Image: Control of Contrel of Control of Contrel o				
Max Out-Of-Pocket\$6,500 IN; \$10,000 CatastrophicInpatient Hospital\$25° copay per admit N*; \$395 copay per admit ONStay\$25° copay per admit N*; \$395 copay ONOutpatient Hospital\$C', \$200 copay IN; \$375 copay ONPockerage\$90° copay IN; \$35 copay ONPreventive/Screening\$00° copay IN; \$35 copay ONPreventive/Screening\$00° copay IN; \$35 copay ONPreventive/Screening\$90° copay IN; \$35 copay ONPreventive/Screening\$00° copay IN; \$35 copay ONPreventive/Screening\$00° copay IN; \$35 copay ONLab & Diagnostic\$20° copay IN*; \$35 copay ONCatage Advanced\$10° copay IN*; \$35 copay ONAvanced Imaging: \$225 copay IN*; \$35 copay ON\$10° copay IN*; \$35 copay ONAdvanced Imaging: \$225 copay IN*; \$35 copay ON\$10° copay IN*; \$35 copay ONAdvanced Imaging: \$225 copay IN*; \$35 copay ON\$10° copay IN*; \$35 copay ONAdvanced Imaging: \$225 copay IN*; \$35 copay ON\$10° copay IN*; \$35 copay ONAdvanced Imaging: \$225 copay IN*; \$35 copay ON\$10° copay IN*; \$35 copay ONAdvanced Imaging: \$225 copay IN*; \$25 copay ONN\$10° copay IN*; \$35 copay ONAdvanced Incer Covercd: \$25 copay IN; \$25 copay ONN\$10° copay IN*; \$35 copay ONPointal Services\$10° copay IN*; \$35 copay ONNPointer Strice Scopay IN; \$25 copay ONN\$10° copay IN*; \$35 copay ONNConcernet Scopay IN; \$35 copay IN\$10° copay IN*; \$35 copay ONNPointer Strice Scopay IN; \$35 copay ON\$10° copay IN*; \$35 copay ONPointer Strice Scopay IN; \$35 copay ONN\$10° copay IN; \$30° copay IN*;		\$0.00		
Inpatient Hospital Stay\$295 copay per admit IN*; \$395 copay per admit OON StayOutpatient Hospital CoverageASC <sup>1</sup> ; \$200 copay IN*; \$325 copay OON Facility; \$250 copay IN*; \$325 copay OON Specialist \$25 copay IN*; \$35 copay OON Specialist \$25 copay IN*; \$25 copay OON Specialist \$25 copay IN*; \$25 copay OON Specialist \$25 copay IN*; \$35 copay OON ONUrgently Needed Services\$30 copay IN/OON28 Alignostic TestsOutpatient; \$25 copay IN*; \$35 copay OON Outpatient; \$25 copay IN*; \$35 copay OON Atvanced Imaging; \$25 copay IN*; \$35 copay OON Atvanced Imaging; \$25 copay IN*; \$35 copay OON Atvanced Imaging; \$25 copay IN*; \$35 copay OON Truitlearing Advanced; \$290 copay; IN*; \$25 copay OON Atvanced Imaging; \$25 copay IN; \$25 copay OON Truitlearing Advanced; \$290 copay; Truitlearing Advanced; \$290 copay; Truitlearing Premuine; \$290 copay IN; \$25 copay OON. Office Visit \$15 copay IN; \$25 copay OON. Routine: \$00 copay IN*; \$10 copay IN*; \$25 copay OON. Routine: \$20 copay IN*;	Deductible	\$0		
StayInternet to the termOutpatient HospitalASC*: \$200 copay IN*: \$325 copay OON SocreagePacifity: \$250 copay IN*; \$325 copay OON Specialis: \$25 copay IN; \$25 copay OON Covered in Full (Office visit copay may apply) IN/OONUrgently Needed Services\$30 copay IN/OONUrgently Needed TestsOffice/Tab: \$0 copay IN*; \$35 copay OON Advanced Imaging: \$225 copay IN*; \$35 copay OON Advanced Imaging: \$225 copay IN*; \$35 copay OON, Routine: \$25 copay IN*; \$35 copay OON, Routine: \$20 copay IN*; \$35 copay OON, \$30 copay perd ap per admit IN*; Day I - 3; \$475 cop	Max Out-Of-Pocket			
CoverageFacility: \$250 copay IN% \$375 copay OONDoctor Office VisitPCP: S0 copay IN% 50 copay OONPreventive/ScreeningCovered in Full (Office visit copay may apply) IN/OONEmergency Room\$90 copay IN/OONUrgently NeededS0 copay IN/S0 copay IN% 535 copay OONServicesOffice/Lab: S0 copay IN*; 535 copay OONLab & DiagnosticOffice/Lab: S0 copay IN*; 535 copay OONAvanced Imaging:S25 copay IN*; 535 copay OONK-Rays/ AdvancedX-ray: S20 copay IN*; 535 copay OONMedicare Covered:S25 copay ONAdvanced Imaging:S25 copay IN*; 535 copay OONRoutine:S25 copay IN*; 535 copay OONRoutine:S25 copay IN*; 525 copay OON.Routine:Routine:Routine:S25 copay IN*; 525 copay OON.Routine:Routine:Routine:S25 copay IN*; 525 copay OON.Routine:S25 copay IN; 525 copay OON.Routine:S25 copay IN; 525 copay OON.Routine:Medicare Covered:S50 copay IN; 525 copay OON.Routine:S50 copay IN; 525 copay OON.Routine:Medicare Covered:S50 copay IN; 525 copay OON.Routine:S50 copay IN; 525 copay OON.Routine:S50 copay IN; 525 copay OON.Routine:S50 copay IN; 525 copay OON.Routine:Medicare Covered:S50 copay IN; 525 copay OON.Routine:Routine:Routine:S50 copay IN; 525 copay OON.Routine:S50 copay IN; 525 copay OON.Routine:S60 copay I		\$295 copay per admit IN*; \$395 copay per admit OON		
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Emergency Room\$90 copay IN/OONUrgently Needed Services\$30 copay IN/ONLab & Diagnostic TestsOffice/Lab: \$0 copay IN*; \$35 copay OON Outpatient: \$25 copay IN*; \$35 copay OON Avary \$20 copay IN*; \$35 copay OON Routine: \$25 copay IN; \$25 copay OON. Routine: \$25 copay IN; \$25 copay OON. Routine: \$25 copay IN; \$25 copay OON. Office Visit: \$15 copay IN; \$30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: \$15 copay IN; \$25 copay OON. Routine: \$0 copay IN; \$50 copay CON (1 Per Year). Standard evgelass lenses and frames or contact lenses are covered in full. IN/OON & \$150 benefit max apfies to non-standard frames or a \$150 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewar (once per operated eye).Mental Health Skilled Nursing FacilitySto copay IN; \$35 copay ON Sto copay per day per admit & Days 4 - 90: \$00 copay per day per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$00 copay per day per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$00 copay per day per admit IN*; S0 copay ON Skilled Nursing FacilitySkilled Nursing Facility\$25 copay ONSkilled Nursing Facility\$25 copay ON Non-Emergent: \$295 copay ONSkilled Nursing Facility	Doctor Office Visit			
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TestsOutpatient: \$25 copay IN*; \$35 copay OONX-Rays/ AdvancedX-ray: \$20 copay IN*; \$35 copay OONHearing ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. Routine: \$25 copay IN; \$25 copay OON. (1 Per Year). TruHearing Premium: \$999 copay (2 Aids Every Year IN); \$500 allowance IN/OON (per year)Dental ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. (1 Per Year). TruHearing Premium: \$999 copay (2 Aids Every Year IN); \$500 allowance IN/OON (per year)Dental ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. (Difice Visit: \$15 copay IN; \$30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance with a maximum \$3,000 allowance IN/OON (Per Year)Vision ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. (Comprehensive: 50% coinsurance with a maximum \$3,000 allowance IN/OON (Per Year) Comprehensive: 50% copay OON. (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit max applies to non-standard frames or a \$150 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewar (once per operated eye).Skilled Nursing FacilitySo copay/day (days 1-20), \$188 copay/day (days 21-100) IN*; 30% coinsurance OONSkilled Nursing FacilitySo copay IN*; \$35 copay OON.Non-Emergent: 30% coinsurance OONSo copay IN*; \$30% coinsurance OONPhysical TherapySo copay IN*; \$35 copay OON.So copay IN*; \$35 copay OON.So copay IN*; \$36 copay INNon-Emergent: 30% coinsurance OONSo copay IN*; \$35 copay OON.Physical TherapySo copay IN*; \$35 copay OON.So copay IN*; \$35 copay OON.So copay IN*; \$35 copay IN*; \$35 copay IN*; \$35 copay	0,	\$30 copay IN/OON		
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Routine: \$25 copay IN; \$25 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 alds Every Year IN); \$500 allowance IN/OON (per year)Dental ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. Office Visit: \$15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: \$15 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance with a maximum \$3,000 allowance IN/OON (Per Year)Vision ServicesMedicare Covered: \$25 copay IN; \$25 copay OON. Routine: \$0 copay IN; \$25 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit max applies to non-standard frames or a \$150 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye).Mental Health ServicesInpatient: Days 1 - 3: \$425 copay per day per admit & Days 4 - 90: \$0 copay per day per admit N*: Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per day per admit N*: Days 1 - 3: \$475 copay yead year admit & Days 4 - 90: \$0 consurance OONSkilled Nursing Facility\$0 copay IN*; \$35 copay ONMember way trip)\$25 copay IN*; \$35 copay ONOrt Sub consurance IN*; 30% coinsurance OONPart B Drugs20% coinsurance ONPart B Drugs20% coinsurance ONOrt Stil allowance one per quarter IN/OONRoutine Podiate equipment\$25 copay IN; \$25 copay ON (4 visits per year)Ourable Medical equipment20% coinsurance ONDurable Medical equipmen				
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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 max applies to non-standard frames or a \$150 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye).Mental Health ServicesInpatient: Days 1 - 3: \$425 copay per day per admit & Days 4 - 90: \$0 copay per day per admit IN*; Days 1 - 3: \$475 	Dental Services	Office Visit: \$15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: \$15 copay IN; 30% coinsurance OON (1 per year).		
Servicescopay per day per admit & Days 4 - 90: \$0 copay per day per admit OON; Outpatient: \$40 copay IN*; \$50 copay OONSkilled Nursing Facility\$0 copay/day (days 1-20), \$188 copay/day (days 21-100) IN*; 30% coinsurance OONPhysical Therapy\$25 copay IN*; \$35 copay OONAmbulance (per one- way trip)Emergent/Non-Emergent: \$295 copay IN**; Non-Emergent: 30% coinsurance OONTransportation\$0 copay IN*; 30% coinsurance OONPart B Drugs20% coinsurance IN*; 30% coinsurance OONOTC\$105 allowance once per quarter IN/OONRoutine Podiatry\$25 copay IN; \$25 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 max applies to non-standard frames or a \$150 benefit max for specialty contact lenses		
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Durable Medical Equipment 20% coinsurance IN*; 30% coinsurance OON   Fitness Benefit Covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	OTC	\$105 allowance once per quarter IN/OON		
Equipment   Fitness Benefit Covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Routine Podiatry	\$25 copay IN; \$25 copay OON (4 visits per year)		
		20% coinsurance IN*; 30% coinsurance OON		
Formulary Performance	Fitness Benefit	Covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON		
i orrenario	Formulary	Performance		

\*Indicates a service that requires prior authorization.

\*\*Indicates a service that requires prior authorization for non-emergent trips.

	Complete Blue PPO Signature			
Premium	\$0.00			
Part B Premium Reduction	\$2.00			
Deductible	\$0			
Max Out-Of-Pocket	\$7,550 IN; \$10,000 Catastrophic			
Inpatient Hospital	Days 1 - 3: \$150 copay per day per admit & Days 4 - 90: \$0 copay per day per admit IN*; Days 1 - 3: \$300 copay per			
Stay	day per admit & Days 4 - 90: \$0 copay per day per admit OON			
Outpatient Hospital Coverage	ASC <sup>1</sup> : \$245 copay IN*; \$325 copay OON Facility: \$295 copay IN*; \$375 copay OON			
Doctor Office Visit	PCP: \$0 copay IN; \$0 copay OON Specialist: \$35 copay IN; \$35 copay OON			
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON			
Emergency Room	\$90 copay IN/OON			
Urgently Needed Services	\$50 copay IN/OON			
Lab & Diagnostic Tests	Office/Lab: \$0 copay IN*; \$50 copay OON Outpatient: \$30 copay IN*; \$50 copay OON			
X-Rays/ Advanced	X-ray: \$20 copay IN*; \$35 copay OON			
Imaging	Advanced Imaging: \$225 copay IN*; \$325 copay OON			
Hearing Services	Medicare Covered: \$35 copay IN; \$35 copay OON. Routine: \$35 copay IN; \$35 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year IN); \$500 allowance IN/OON (per year)			
Dental Services	Medicare Covered: \$35 copay IN; \$35 copay OON. Office Visit: \$15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: \$15 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)			
Vision Services	Medicare Covered: \$35 copay IN; \$35 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 max applies to non-standard frames or a \$150 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye).			
Mental Health Services	Inpatient: Days 1 - 3: \$425 copay per day per admit & Days 4 - 90: \$0 copay per day per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per day per admit OON; Outpatient: \$40 copay IN*; \$50 copay OON			
Skilled Nursing Facility	\$0 copay/day (days 1-20), \$188 copay/day (days 21-100) IN*; 30% coinsurance OON			
Physical Therapy	\$30 copay IN*; \$35 copay 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	\$75 allowance once per quarter IN/OON			
Routine Podiatry	\$35 copay IN; \$35 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			
Formulary	Performance			

\*Indicates a service that requires prior authorization. \*\*Indicates a service that requires prior authorization for non-emergent trips.

#### Complete Blue PPO Distinct

You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

	Initial 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 5 (Specialty Tier)	33% of the cost	Not Applicable	
		Standard Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply	
			Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay	
			Tier 2 (Generic)	\$20 Copay	\$60 Copay	
D			Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
			Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
R			Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
U		Standard Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply	
G			Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay	
			Tier 2 (Generic)	Not Applicable	\$0 Copay	
			Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay	
			Tier 4 (Non-Preferred Drug)	Not Applicable	\$280 Copay	
			Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
	Coverage Gap	After you enter	gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430. er the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for ric drugs until your costs total \$7,050, which is the end of the coverage gap. Not everyone will enter the coverage			
		Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)				
	Catastrophic	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$7,050, you pay the greater of: 5% of the cost, or \$3.95 Copay for generics and a \$9.85 Copay for all other drugs.				
	Coverage	Greater of: 5% or \$3.95 Generic / Preferred Multi-Source or \$9.85 for all others				

#### **Complete Blue PPO Signature**

You pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

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	Initial Coverage	Preferred Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
			Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay		
			Tier 2 (Generic)	\$7 Copay	\$21 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 Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
			Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay		
D			Tier 2 (Generic)	\$15 Copay	\$45 Copay		
			Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
			Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
R			Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
U		Standard Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
G			Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay		
			Tier 2 (Generic)	Not Applicable	\$0 Copay		
			Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay		
			Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay		
			Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4 After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost covered generic drugs until your costs total \$7,050, which is the end of the coverage gap. Not everyone will enter the cov gap.					
		Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)					
	Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$7,050, you pay the greater of: 5% of the cost, or \$3.95 Copay for generics and a \$9.85 Copay for all other drugs.					
		Greater of: 5% or \$3.95 Generic / Preferred Multi-Source or \$9.85 for all others					



Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Cross Blue Shield provides certain administrative communications for this company. Highmark Blue Cross Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross Blue Shield Association. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration.

Out-of-network/non-contracted providers are under no obligation to treat Complete Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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 1-833-544-1060 (TTY users may call 711) for more information.

TruHearing is a registered trademark of TruHearing, Inc.

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