Residents of Carbon County, **please click here.**

Residents of the following counties: Bradford, Lackawanna, Luzerne, Susquehanna, Wayne, Wyoming, **please click here.**

Residents of Monroe County: **please click here.**

Residents of the following counties: Pike **please click here.**

Residents of the following counties: Clinton, Lycoming, Sullivan, Tioga, **please click here.**

Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020
Covered Counties: Clinton, Lycoming, Sullivan, Tioga

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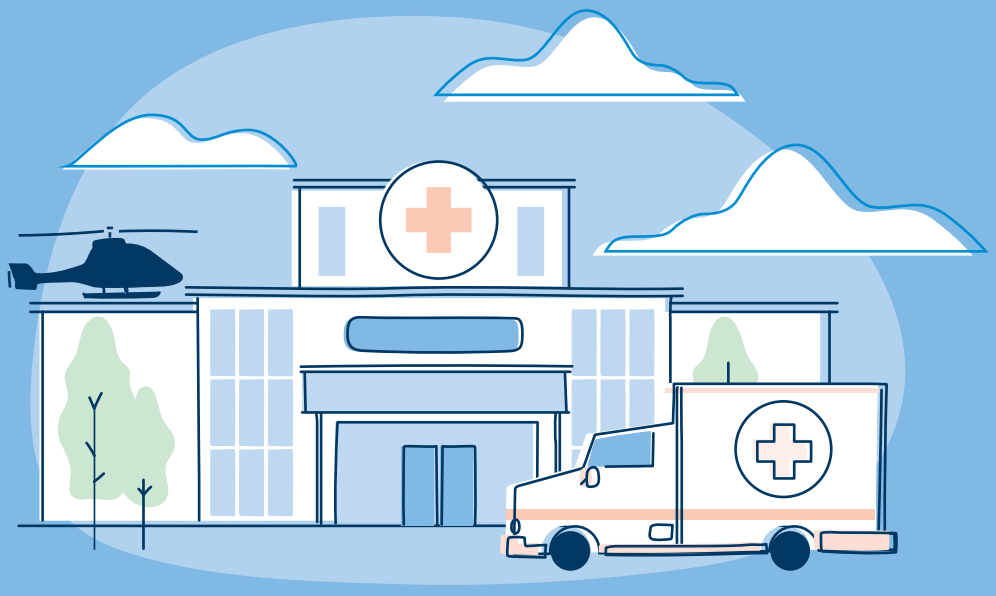

Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

*Blue Cross and Blue Shield System, bcbs.com

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

step 1 Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

step 2 If your needs change during the year, tell us. We'll review your coverage with you.

step 3 If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

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- Visit a Highmark Direct store or a local Medicare seminar
- Go to **YourHighmarkPlan.com**

OON = Out-of-Network

			Community Blue Medicare Plus PPO Signature	Community Blue Medicare Plus PPO Distinct	Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
Health	Basic Plan Costs	Monthly Plan Premium[1]	$0	$35	$77	$70	$185.50	$288.50
Health	Basic Plan Costs	Out-of-Pocket Maximum	In-Network: $6,700 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,500 | Catastrophic: $10,000	In-Network: $5,000 | Catastrophic: $10,000	In-Network: $4,500 | Catastrophic: $10,000
Health	Physician Services	Doctor Office Per Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $0 Copay IN; $0 Copay OON Specialist: $30 Copay IN; $30 Copay OON	PCP: $10 Copay IN; $10 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $40 Copay IN; $40 Copay OON	PCP:$5 Copay IN; $5 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $30 Copay IN; $30 Copay OON
Health	Physician Services	Lab & Diagnostic Tests	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $15 Copay OON Outpatient: $15 Copay IN; $15 Copay OON	Office/Lab: $0 Copay IN; $10 Copay OON Outpatient: $10 Copay IN; $10 Copay OON
Health	Physician Services	X-rays/Advanced Imaging	X-ray: $40 Copay IN; $60 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $35 Copay IN; $50 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $200 Copay IN; $200 Copay OON	X-ray: $20 Copay IN; $20 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $10 Copay IN; $10 Copay OON Advanced Imaging: $100 Copay IN; $100 Copay OON
Health	Facility Services	Outpatient Surgery	ASC: $275 Copay IN; $425 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $225 Copay IN; $375 Copay OON Facility: $275 Copay IN; $375 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $275 Copay OON Facility: $275 Copay IN; $275 Copay OON	ASC: $150 Copay IN; $250 Copay OON Facility: $250 Copay IN; $250 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON
Health	Facility Services	Emergency Room/Urgent Care	Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	
Health	Facility Services	Inpatient Hospital Stay	$395 Copay Per Admit IN; $275/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$375 Copay Per Admit IN; $200/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$340 Copay Per Admit IN; $340 Copay Per Admit OON	$245/day Copay (days 1-5), $0/day Copay (days 6-90) IN; $245/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$475 Copay Per Admit IN; $475 Copay Per Admit OON	$235 Copay Per Admit IN; $235 Copay Per Admit OON
Health	Facility Services	Skilled Nursing Facility	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)			$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	
Health	Additional Benefits	Routine Hearing (2 Hearing Aids per year)	Exam: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $30 Copay IN; $30 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $40 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $30 Copay OON (1 Per Year). TruHearing Enhanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)
Health	Additional Benefits	Routine Dental	Office 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 $2000 allowance IN/OON (Per Year)	Office 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 $2000 allowance IN/OON (Per Year)	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
Health	Additional Benefits	Routine Vision (Annually)	Exam: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operared eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).
Health	Additional Benefits	Routine Chiropractic/ Podiatry	Chiropractic: $20 Copay IN; $35 Copay OON (4 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (4 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $40 Copay OON (6 Visits Per Year) Podiatry: $40 Copay IN; $40 Copay OON (8 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (10 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (12 Visits Per Year)
Drug	Part D Drugs (Up To 31 Days)	Formulary	Performance	Performance	Not Covered	Performance	Venture	Venture
Drug	Part D Drugs (Up To 31 Days)	Initial Coverage- Up to $4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%
Drug	Part D Drugs (Up To 31 Days)	Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 ($0) Generics: Tier 2 ($13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 ($5) Generics: Tier 2 ($19) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount)
Drug	Part D Drugs (Up To 31 Days)	Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95		Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		

**Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

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.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members and/or 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.

Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020
Covered Counties: Monroe

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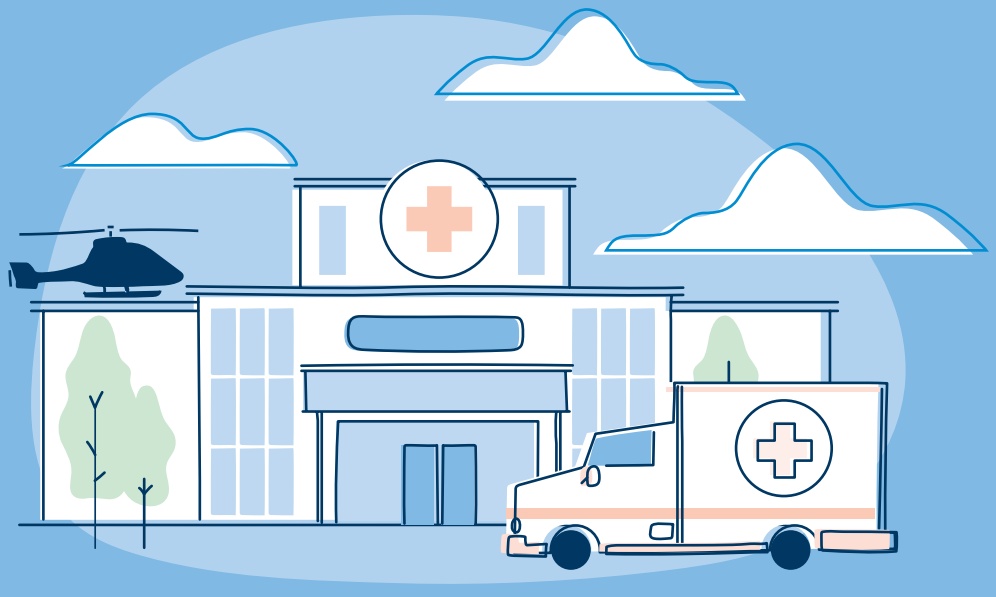

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POS = Point-of-Service

			Community Blue Medicare HMO Signature	Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
Health	Basic Plan Costs	Monthly Plan Premium[1]	$0	$0	$35	$77	$70	$185.50	$288.50
		Out-of-Pocket Maximum	In-Network: $5,900	In-Network: $6,700 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,500 | Catastrophic: $10,000	In-Network: $5,000 | Catastrophic: $10,000	In-Network: $4,500 | Catastrophic: $10,000
	Physician Services	Doctor Office Per Visit	PCP: $0 Copay Specialist: $25 Copay	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $0 Copay IN; $0 Copay OON Specialist: $30 Copay IN; $30 Copay OON	PCP: $10 Copay IN; $10 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $40 Copay IN; $40 Copay OON	PCP:$5 Copay IN; $5 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $30 Copay IN; $30 Copay OON
		Lab & Diagnostic Tests	Office/Lab: $0 Copay Outpatient: $30 Copay	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $15 Copay OON Outpatient: $15 Copay IN; $15 Copay OON	Office/Lab: $0 Copay IN; $10 Copay OON Outpatient: $10 Copay IN; $10 Copay OON
		X-rays/Advanced Imaging	X-ray: $30 Copay Advanced Imaging: $225 Copay	X-ray: $40 Copay IN; $60 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $30 Copay IN; $40 Copay OON Advanced Imaging: $225 Copay IN; $300 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $200 Copay IN; $200 Copay OON	X-ray: $20 Copay IN; $20 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $10 Copay IN; $10 Copay OON Advanced Imaging: $100 Copay IN; $100 Copay OON
	Facility Services	Outpatient Surgery	ASC: $200 Copay Facility: $275 Copay	ASC: $275 Copay IN; $425 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $200 Copay IN; $325 Copay OON Facility: $275 Copay IN; $325 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $275 Copay OON Facility: $275 Copay IN; $275 Copay OON	ASC: $150 Copay IN; $250 Copay OON Facility: $250 Copay IN; $250 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON
		Emergency Room/Urgent Care		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	
		Inpatient Hospital Stay	$295 Copay Per Admit	$395 Copay Per Admit IN; $225/day Copay (days 1-7), $0/day (days 8-90) OON	$325 Copay Per Admit IN; $375 Copay Per Admit OON	$340 Copay Per Admit IN; $340 Copay Per Admit OON	$245/day Copay (days 1-5), $0/day Copay (days 6-90) IN; $245/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$475 Copay Per Admit IN; $475 Copay Per Admit OON	$235 Copay Per Admit IN; $235 Copay Per Admit OON
		Skilled Nursing Facility		$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)		$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)		
	Additional Benefits	Routine Hearing (2 Hearing Aids per year)	Exam: $0 Copay (1 Per Year) TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year)	Exam: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $30 Copay IN; $30 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $40 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $30 Copay OON (1 Per Year). TruHearing Enhanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)
		Routine Dental	Office Visit: $0 Copay (1 Per Six Months) X-Rays: $0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum $2000 allowance (Per Year)	Office 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 $2,000 allowance IN/OON (Per Year)	Office 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 $2,000 allowance IN/OON (Per Year)	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
		Routine Vision (Annually)	Exam: $0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. 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).	Exam: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operared eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).
		Routine Chiropractic/ Podiatry	Chiropractic: $20 Copay IN (4 Visits Per Year) Podiatry: $25 Copay IN (4 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (4 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (4 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN, $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN, $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $40 Copay OON (6 Visits Per Year) Podiatry: $40 Copay IN; $40 Copay OON (8 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (10 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (12 Visits Per Year)
Drug	Part D Drugs (Up To 31 Days)	Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture
		Initial Coverage- Up to $4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%
		Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 ($0) Generics: Tier 2 ($13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 ($5) Generics: Tier 2 ($19) Generics Tiers 3-5 (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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		Not Covered		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.	

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Freedom Blue PPO Medicare Advantage products.

**Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

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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.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members and/or 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.

Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020
Covered Counties: Carbon

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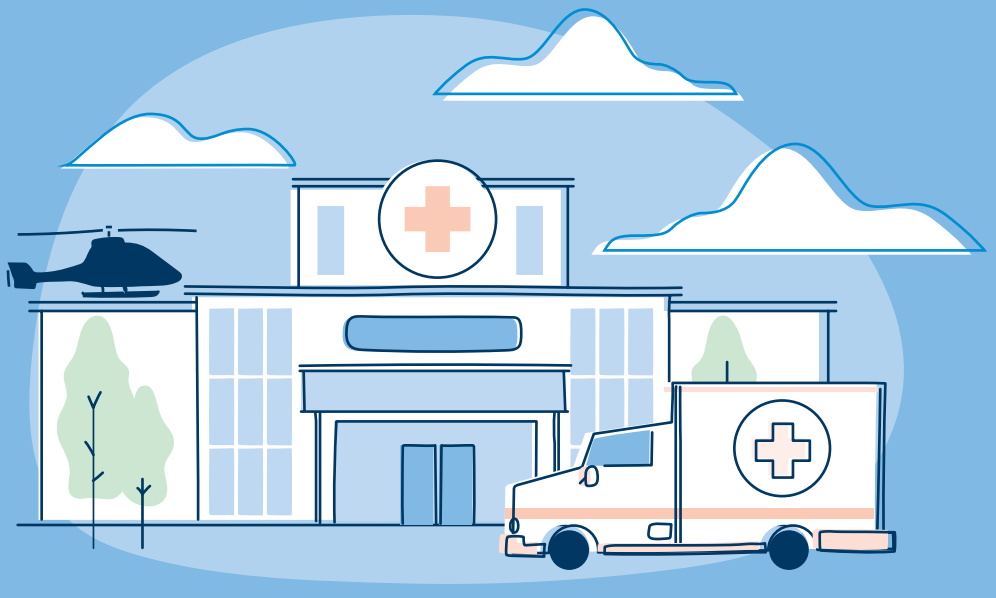

Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

*Blue Cross and Blue Shield System, bcbs.com

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

step 1 Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

step 2 If your needs change during the year, tell us. We'll review your coverage with you.

step 3 If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

- Call **1-800-207-9304** (8 a.m.–8 p.m., seven days a week, TTY users call 711)
- Visit a Highmark Direct store or a local Medicare seminar
- Go to **YourHighmarkPlan.com**

OON = Out-of-Network
POS = Point-of-Service

			Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
Health	Basic Plan Costs	Monthly Plan Premium[1]	$0	$35	$77	$70	$185.50	$288.50
		Out-of-Pocket Maximum	In-Network: $6,700 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,500 | Catastrophic: $10,000	In-Network: $5,000 | Catastrophic: $10,000	In-Network: $4,500 | Catastrophic: $10,000
	Physician Services	Doctor Office Per Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $0 Copay IN; $0 Copay OON Specialist: $30 Copay IN; $30 Copay OON	PCP: $10 Copay IN; $10 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $40 Copay IN; $40 Copay OON	PCP:$5 Copay IN; $5 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $30 Copay IN; $30 Copay OON
		Lab & Diagnostic Tests	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $15 Copay OON Outpatient: $15 Copay IN; $15 Copay OON	Office/Lab: $0 Copay IN; $10 Copay OON Outpatient: $10 Copay IN; $10 Copay OON
		X-rays/Advanced Imaging	X-ray: $40 Copay IN; $60 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $30 Copay IN; $40 Copay OON Advanced Imaging: $225 Copay IN; $300 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $200 Copay IN; $200 Copay OON	X-ray: $20 Copay IN; $20 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $10 Copay IN; $10 Copay OON Advanced Imaging: $100 Copay IN; $100 Copay OON
	Facility Services	Outpatient Surgery	ASC: $275 Copay IN; $425 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $200 Copay IN; $325 Copay OON Facility: $275 Copay IN; $325 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $275 Copay OON Facility: $275 Copay IN; $275 Copay OON	ASC: $150 Copay IN; $250 Copay OON Facility: $250 Copay IN; $250 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON
		Emergency Room/Urgent Care	Emergency: $90 Copay; Urgent Care: $50 Copay		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	
		Inpatient Hospital Stay	$395 Copay Per Admit IN; $225/day Copay (days 1-7), $0/day (days 8-90) OON	$325 Copay Per Admit IN; $375 Copay Per Admit OON	$340 Copay Per Admit IN; $340 Copay Per Admit OON	$245/day Copay (days 1-5), $0/day Copay (days 6-90) IN; $245/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$475 Copay Per Admit IN; $475 Copay Per Admit OON	$235 Copay Per Admit IN; $235 Copay Per Admit OON
		Skilled Nursing Facility	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)			$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	
	Additional Benefits	Routine Hearing (2 Hearing Aids per year)	Exam: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $30 Copay IN; $30 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $40 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $30 Copay OON (1 Per Year). TruHearing Enhanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)
		Routine Dental	Office 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 $2,000 allowance IN/OON (Per Year)	Office 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 $2,000 allowance IN/OON (Per Year)	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
		Routine Vision (Annually)	Exam: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operared eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).
		Routine Chiropractic/ Podiatry	Chiropractic: $20 Copay IN; $35 Copay OON (4 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (4 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN, $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN, $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $40 Copay OON (6 Visits Per Year) Podiatry: $40 Copay IN; $40 Copay OON (8 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (10 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (12 Visits Per Year)
Drug	Part D Drugs (Up To 31 Days)	Formulary	Performance	Performance	Not Covered	Performance	Venture	Venture
		Initial Coverage- Up to $4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%
		Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 ($0) Generics: Tier 2 ($13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 ($5) Generics: Tier 2 ($19) Generics Tiers 3-5 (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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		

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Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020
Covered Counties: Bradford, Lackawanna, Luzerne, Susquehanna, Wayne, Wyoming

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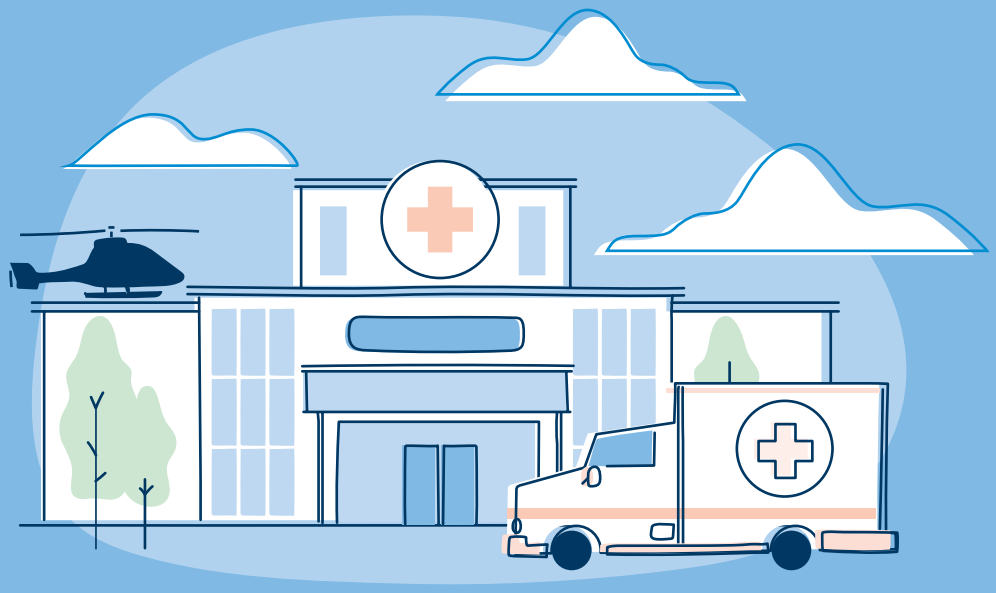

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OON = Out-of-Network
POS = Point-of-Service

			Community Blue Medicare HMO Signature	Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
Health	Basic Plan Costs	Monthly Plan Premium[1]	$0	$0	$35	$77	$70	$185.50	$288.50
		Out-of-Pocket Maximum	In-Network: $5,500	In-Network: $6,700 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,500 | Catastrophic: $10,000	In-Network: $5,000 | Catastrophic: $10,000	In-Network: $4,500 | Catastrophic: $10,000
	Physician Services	Doctor Office Per Visit	PCP: $0 Copay Specialist: $20 Copay	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $0 Copay IN; $0 Copay OON Specialist: $30 Copay IN; $30 Copay OON	PCP: $10 Copay IN; $10 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $40 Copay IN; $40 Copay OON	PCP:$5 Copay IN; $5 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $30 Copay IN; $30 Copay OON
		Lab & Diagnostic Tests	Office/Lab: $0 Copay Outpatient: $30 Copay	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $15 Copay OON Outpatient: $15 Copay IN; $15 Copay OON	Office/Lab: $0 Copay IN; $10 Copay OON Outpatient: $10 Copay IN; $10 Copay OON
		X-rays/Advanced Imaging	X-ray: $30 Copay Advanced Imaging: $225 Copay	X-ray: $40 Copay IN; $60 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $30 Copay IN; $40 Copay OON Advanced Imaging: $225 Copay IN; $300 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $200 Copay IN; $200 Copay OON	X-ray: $20 Copay IN; $20 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $10 Copay IN; $10 Copay OON Advanced Imaging: $100 Copay IN; $100 Copay OON
	Facility Services	Outpatient Surgery	ASC: $125 Copay Facility: $175 Copay	ASC: $275 Copay IN; $425 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $200 Copay IN; $325 Copay OON Facility: $275 Copay IN; $325 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $275 Copay OON Facility: $275 Copay IN; $275 Copay OON	ASC: $150 Copay IN; $250 Copay OON Facility: $250 Copay IN; $250 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON
		Emergency Room/Urgent Care		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	
		Inpatient Hospital Stay	$250 Copay Per Admit	$395 Copay Per Admit IN; $225/day Copay (days 1-7), $0/day (days 8-90) OON	$325 Copay Per Admit IN; $375 Copay Per Admit OON	$340 Copay Per Admit IN; $340 Copay Per Admit OON	$245/day Copay (days 1-5), $0/day Copay (days 6-90) IN; $245/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$475 Copay Per Admit IN; $475 Copay Per Admit OON	$235 Copay Per Admit IN; $235 Copay Per Admit OON
		Skilled Nursing Facility		$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)		$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)		$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	
	Additional Benefits	Routine Hearing (2 Hearing Aids per year)	Not Covered	Exam: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $30 Copay IN; $30 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $40 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $30 Copay OON (1 Per Year). TruHearing Enhanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)
		Routine Dental	Not Covered	Office 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 $2,000 allowance IN/OON (Per Year)	Office 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 $2,000 allowance IN/OON (Per Year)	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
		Routine Vision (Annually)	Not Covered	Exam: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operared eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).
		Routine Chiropractic/ Podiatry	Not Covered	Chiropractic: $20 Copay IN; $35 Copay OON (4 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (4 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN, $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN, $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $40 Copay OON (6 Visits Per Year) Podiatry: $40 Copay IN; $40 Copay OON (8 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (10 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (12 Visits Per Year)
Drug	Part D Drugs (Up To 31 Days)	Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture
		Initial Coverage- Up to $4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%
		Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 ($0) Generics: Tier 2 ($13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 ($5) Generics: Tier 2 ($19) Generics Tiers 3-5 (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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.			Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Freedom Blue PPO Medicare Advantage products.

**Does not apply to all benefits across all plans.

This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

TruHearing is a registered trademark of TruHearing, Inc.

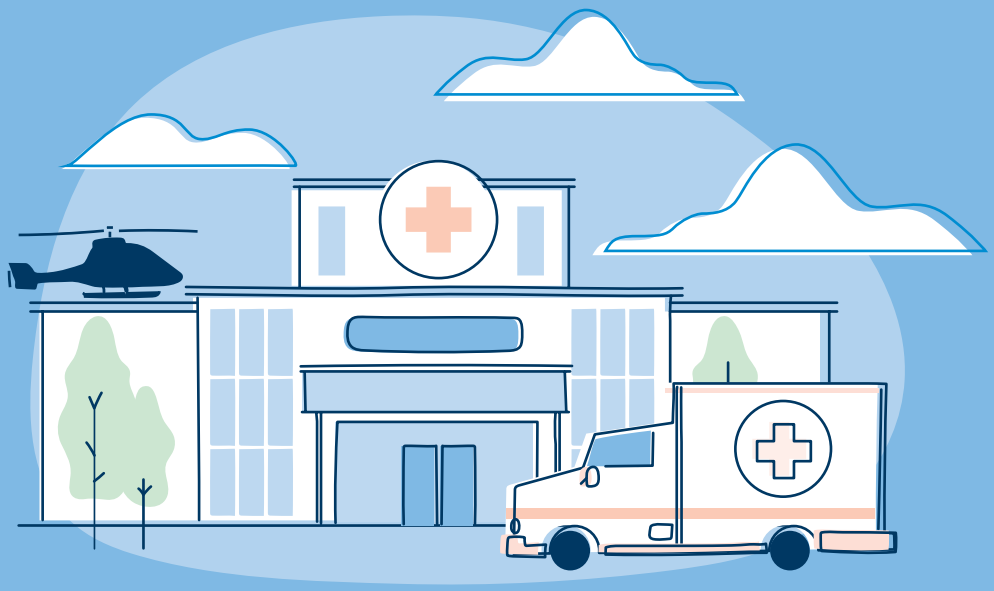
SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members and/or 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.

Let's look at your options for a 2020 Medicare Advantage plan.

Medicare Plan Comparison Guide 2020
Covered Counties: Pike

HIGHMARK



Highmark is part of a network that's been providing secure and stable health care coverage for over 80 years. And with one in three Americans* covered by that same network today, when you're with Highmark, you're in good company.

*Blue Cross and Blue Shield System, bcbs.com

The right plan for you. Guaranteed.

With how complex Medicare can be, choosing the right coverage is especially important. That's why, exclusively for our Medicare members, we've introduced Highmark Right Fit Guarantee.

HOW IT WORKS:

step 1 Based on your health, finances, and future plans, we'll make sure your current plan is still right for you.

step 2 If your needs change during the year, tell us. We'll review your coverage with you.

step 3 If there's a plan that fits better, we'll help you find it.

That's our promise. Whether it's over the phone, in person, or with our plan recommendation tools, we guarantee we'll always be here to make sure you've got the right fit plan.

- Call **1-800-207-9304** (8 a.m.–8 p.m., seven days a week, TTY users call 711)
- Visit a Highmark Direct store or a local Medicare seminar
- Go to **YourHighmarkPlan.com**

OON = Out-of-Network

			Community Blue Medicare PPO Signature	Community Blue Medicare PPO Distinct	Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe
Health	Basic Plan Costs	Monthly Plan Premium[1]	$0	$35	$77	$70	$185.50	$288.50
		Out-of-Pocket Maximum	In-Network: $6,700 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,900 | Catastrophic: $10,000	In-Network: $5,500 | Catastrophic: $10,000	In-Network: $5,000 | Catastrophic: $10,000	In-Network: $4,500 | Catastrophic: $10,000
	Physician Services	Doctor Office Per Visit	PCP: $0 Copay IN; $0 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $0 Copay IN; $0 Copay OON Specialist: $30 Copay IN; $30 Copay OON	PCP: $10 Copay IN; $10 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $40 Copay IN; $40 Copay OON	PCP:$5 Copay IN; $5 Copay OON Specialist: $35 Copay IN; $35 Copay OON	PCP: $5 Copay IN; $5 Copay OON Specialist: $30 Copay IN; $30 Copay OON
		Lab & Diagnostic Tests	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $40 Copay OON Outpatient: $30 Copay IN; $40 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $20 Copay OON Outpatient: $20 Copay IN; $20 Copay OON	Office/Lab: $0 Copay IN; $15 Copay OON Outpatient: $15 Copay IN; $15 Copay OON	Office/Lab: $0 Copay IN; $10 Copay OON Outpatient: $10 Copay IN; $10 Copay OON
		X-rays/Advanced Imaging	X-ray: $40 Copay IN; $60 Copay OON Advanced Imaging: $270 Copay IN; $370 Copay OON	X-ray: $30 Copay IN; $40 Copay OON Advanced Imaging: $225 Copay IN; $300 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $25 Copay IN; $25 Copay OON Advanced Imaging: $200 Copay IN; $200 Copay OON	X-ray: $20 Copay IN; $20 Copay OON Advanced Imaging: $150 Copay IN; $150 Copay OON	X-ray: $10 Copay IN; $10 Copay OON Advanced Imaging: $100 Copay IN; $100 Copay OON
	Facility Services	Outpatient Surgery	ASC: $275 Copay IN; $425 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $200 Copay IN; $325 Copay OON Facility: $275 Copay IN; $325 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $275 Copay OON Facility: $275 Copay IN; $275 Copay OON	ASC: $150 Copay IN; $250 Copay OON Facility: $250 Copay IN; $250 Copay OON	ASC: $100 Copay IN; $200 Copay OON Facility: $200 Copay IN; $200 Copay OON
		Emergency Room/Urgent Care	Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay		Emergency: $90 Copay; Urgent Care: $50 Copay	Emergency: $90 Copay; Urgent Care: $50 Copay	
		Inpatient Hospital Stay	$395 Copay Per Admit IN; $225/day Copay (days 1-7), $0/day (days 8-90) OON	$325 Copay Per Admit IN; $375 Copay Per Admit OON	$340 Copay Per Admit IN; $340 Copay Per Admit OON	$245/day Copay (days 1-5), $0/day Copay (days 6-90) IN; $245/day Copay (days 1-5), $0/day Copay (days 6-90) OON	$475 Copay Per Admit IN; $475 Copay Per Admit OON	$235 Copay Per Admit IN; $235 Copay Per Admit OON
		Skilled Nursing Facility	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)			$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	$0 Per Day (Days 1-20), $178 Per Day (Days 21-100)	
	Additional Benefits	Routine Hearing (2 Hearing Aids per year)	Exam: $35 Copay IN; $35 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $30 Copay IN; $30 Copay OON (1 Per Year). TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $40 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $35 Copay OON (1 Per Year). TruHearing Enhanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)	Exam: $0 Copay IN; $30 Copay OON (1 Per Year). TruHearing Enhanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year IN); $500 Allowance OON (Per Year)
		Routine Dental	Office 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 $2,000 allowance IN/OON (Per Year)	Office 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 $2,000 allowance IN/OON (Per Year)	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).	Office Visit: $15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: $15 Copay IN; 30% Coinsurance OON (1 Per Year).
		Routine Vision (Annually)	Exam: $0 Copay IN; $50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operared eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).	Exam: $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. $200 benefit maximum for post cataract eyewear (once per operated eye).
		Routine Chiropractic/ Podiatry	Chiropractic: $20 Copay IN; $35 Copay OON (4 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (4 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (4 Visits Per Year)	Chiropractic: $20 Copay IN, $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN, $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $40 Copay OON (6 Visits Per Year) Podiatry: $40 Copay IN; $40 Copay OON (8 Visits Per Year)	Chiropractic: $20 Copay IN; $35 Copay OON (8 Visits Per Year) Podiatry: $35 Copay IN; $35 Copay OON (10 Visits Per Year)	Chiropractic: $20 Copay IN; $30 Copay OON (10 Visits Per Year) Podiatry: $30 Copay IN; $30 Copay OON (12 Visits Per Year)
Drug	Part D Drugs (Up To 31 Days)	Formulary	Performance	Performance	Not Covered	Performance	Venture	Venture
		Initial Coverage- Up to $4,020 in total Rx Costs Tier 1: Preferred Generic, Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, Tier 5: Specialty	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: $47, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Not Covered	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $13, Tier 3: $45, Tier 4: $95, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, Tier 5: 33%
		Coverage Gap	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Not Covered	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Generic (25% Coinsurance), Brand (25% Coinsurance including 70% discount)	Preferred Retail: Generics: Tier 1 ($0) Generics: Tier 2 ($13) Generics Tiers 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount) Standard Retail: Generics: Tier 1 ($5) Generics: Tier 2 ($19) Generics Tiers 3-5 (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 $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.		

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