Residents of the following counties: Lehigh, Northampton, Schuylkill, please click here.

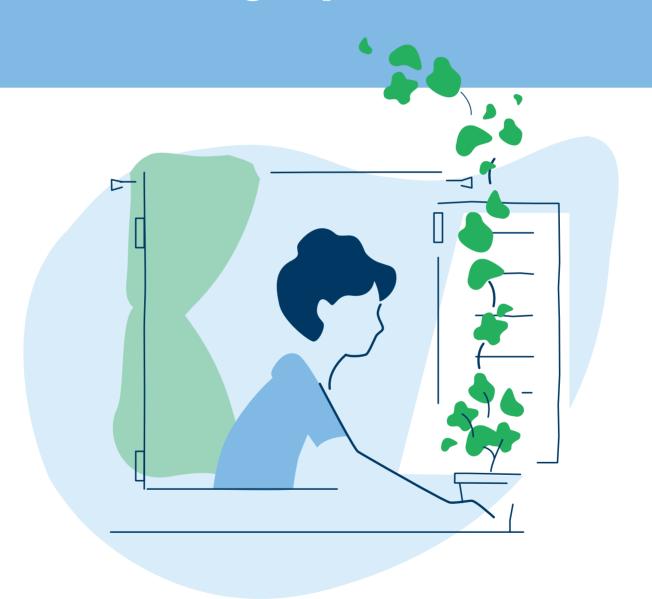
Residents of the following counties: Adams, Cumberland, Dauphin, Juniata, Lebanon, Perry, York, **please click here.** 

Residents of the following counties: Berks, Snyder, Union, please click here.

Residents of the Lancaster County please click here.

Residents of the following counties: Centre, Franklin, Fulton, Mifflin, please click here.

Residents of the following counties: Columbia, Montour, Northumberland, please click here.







# 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.

# step 1



### **HOW IT WORKS:**

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 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
V Monthly Plan Prem	\$0	\$0	\$35	\$77	\$70	\$185.50	\$288.50
Out-of-Pocket Max	mum 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
Doctor Office Per	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 1	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/Advance 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
Outpatient Surg	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/U	gent	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent C	are: \$50 Copay Emergence	y: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay	
Inpatient Hospital	\$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 Fac	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)			\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	ay (Days 1-20), \$178 Per Day (Days 21-100) \$0 Per Day (Days 21-100)		
Routine Hearin (2 Hearing Aids per		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 Denta	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)	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).	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 (Ann	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).  Chiropractic: \$20 Copay IN; \$35 Copay OON (4 Visits Per Year)	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	benefit maximum applies to non-standard frames or a \$150 benefit	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	benefit maximum applies to non-standard frames or a \$150 benefit	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).  Chiropractic: \$20 Copay IN; \$30 Copay OON (10 Visits Per Year)
Podiatry	Podiatry: \$25 Copay IN (4 Visits Per Year)	Podiatry: \$35 Copay IN; \$35 Copay OON (4 Visits Per Year)	Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Podiatry: \$35 Copay IN; \$35 Copay OON (10 Visits Per Year)	Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	Podiatry: \$35 Copay IN; \$35 Copay OON (10 Visits Per Year)	Podiatry: \$30 Copay IN; \$30 Copay OON (12 Visits Per Year)
Formulary Initial Coverage - U \$4,020 in total Rx C		Performance	Performance	Not Covered	Performance	Venture	Venture
Tier 1: Preferred Ge Tier 2: Generic, Tie	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% r 3:	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:	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:	Not Covered	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33%
Tier 4: Non-Prefer Drug, Tier 5: Specialt	red 33%	33%	33%		Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Coverage Gap	Gaparia (25% Caingurance) Brand	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 Cove	After your yearly out-of-pocket drug costs (including drugs purchased the	hrough your retail pharmacy and through mail order) reaches \$6,350, you pa Copay for all other drugs.	ay 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 to	through your retail pharmacy and through mail order) reaches \$6,350, you page Copay for all other drugs.	eay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

**Does not	annly to all bene	fits across all plai	ne		

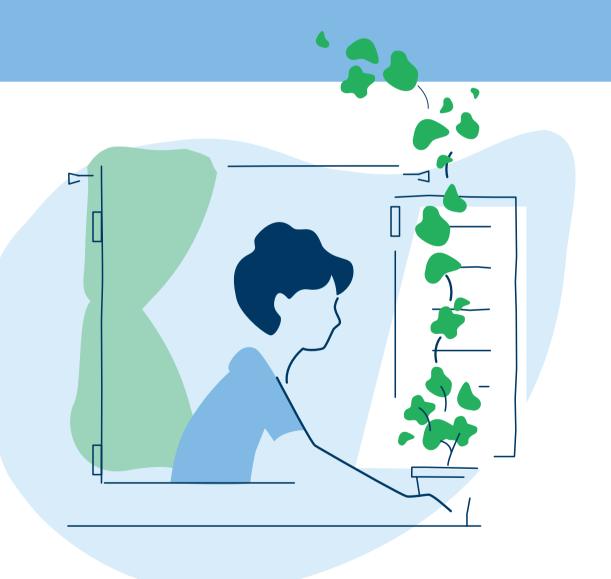
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SilverSneakers is a registered mark of Tivity Health, Inc. Tivity Health, Inc. is a separate company that administers the SilverSneakers program.

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.

Y0037\_19\_4233\_M PG20\_AEP\_CPA\_CB\_1



Medicare Plan Comparison Guide 2020 Covered Counties: Centre, Franklin, Fulton, Mifflin





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ON = 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
Monthly Plan Premium <sup>1</sup>	\$O	\$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
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
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 C	are: \$50 Copay	mergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Co	pay
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	s 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (D	ys 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (Days 1-20), \$178	Per Day (Days 21-100)
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)
- Pouting 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).		Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Month 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	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	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 eyeglas lenses and frames or contact lenses are covered in full. IN/OON: A \$1 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum 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 (4Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4Visits 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)
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 Tier 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tier 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discount
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased the	nrough your retail pharmacy and through mail order) reaches \$6,350, you \$3.60 Copay for generics and a \$8.95	Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased the	hrough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	

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

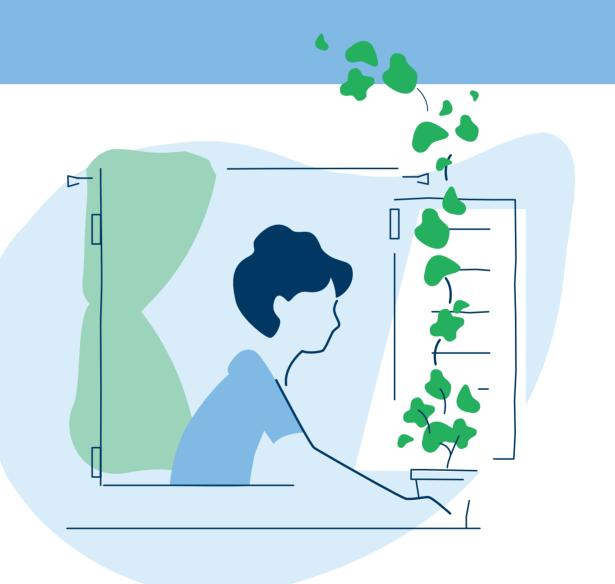
This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information.

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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-Net	twork	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
Costs Wor	nthly Plan Premium <sup>1</sup>	\$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
E w	octor 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
nysicia ervices	b & 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
T W	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
y Ot	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
Emer	ergency Room/Urgent Care		Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent C	are: \$50 Copay Emergence	ey: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay	
ealth cility s	oatient 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
Ĭ Skil	illed Nursing Facility		\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-10	00)	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per D	Day (Days 1-20), \$178 Per Day (Days 21-100)	
	Routine Hearing earing 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)
ional	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)	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).	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year).
Addit Ben	tine Vision (Annually)	Not Covered	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	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	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		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).
Rou	outine 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 (4Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4Visits 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)
	Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture
Sanda Tier 1 Tier 5 31 Days) Tier 5	tial Coverage- Up to 020 in total Rx Costs 1: Preferred Generic, er 2: Generic, Tier 3: Preferred Brand, er 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%
9 D	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)
Cato	tastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased the	rough your retail pharmacy and through mail order) reaches \$6,350, you per Copay for all other drugs.	ay 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 the	nrough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

**Does not app	ly to all benefits across all plans.
	n is not a complete description of benefits. Call the phone number on the back of your member ID of call 711) for more information.
-	ce Company and Highmark Senior Health Company are Medicare Advantage plans with a Medica

TruHearing is a registered trademark of TruHearing, Inc.

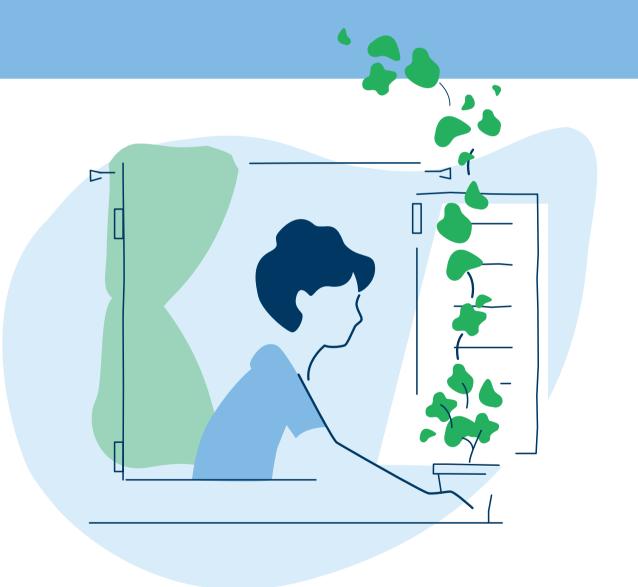
the Blue Cross and Blue Shield Association.

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.

Highmark Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of

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# 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.

# step 1

### **HOW IT WORKS:**

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 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
isic Costs	Monthly Plan Premium <sup>1</sup>	\$0	\$0	\$35	\$77	\$70	\$185.50	\$288.50
Ba	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
ς <sub>ω</sub>	Doctor Office Per Visit	PCP: \$0 Copay Specialist: \$20 Copay	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 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
nysicia	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; \$35 Copay OON Outpatient: \$30 Copay IN; \$35 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: \$25 Copay IN; \$50 Copay OON Advanced Imaging: \$270 Copay IN; \$370 Copay OON	X-ray: \$25 Copay IN; \$50 Copay OON Advanced Imaging: \$175 Copay IN; \$275 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
ဟ	Outpatient Surgery	ASC: \$125 Copay Facility: \$175 Copay	ASC: \$225 Copay IN; \$450 Copay OON Facility: \$300 Copay IN; \$450 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
ervice	Emergency Room/Urgent Care	Emergency: \$90 Copay; Urger	nt Care: \$50 Copay Emerger	ncy: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care:	\$50 Copay Emergency: \$90	0 Copay; Urgent Care: \$50 Copay
ealth	Inpatient Hospital Stay	\$250 Copay Per Admit	\$395 Copay Per Admit IN; \$275/day Copay (days 1-5), \$0/day (days 6-90) OON	\$275 Copay Per Admit IN; \$325 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
ĬĬ º	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 Da	y (Days 1-20), \$178 Per Day (Days 21-100)	\$0 Per Day (Days 1-20), \$	178 Per Day (Days 21-100)
	Routine Hearing (2 Hearing Aids per year)	Not Covered	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: \$25 Copay IN; \$25 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)
ional	Routine Dental	Not Covered	Office Visit: \$0 Copay IN; 30% Coinsurance OON (1 Per Six Months).  X-Rays: \$0 Copay IN; 30% Coinsurance OON (1 Per Year).  Comprehensive: 50% Coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)	X-Rays: \$0 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).	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year).
Addi	Routine Vision (Annually)	Not Covered	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	lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames per year and a \$150	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	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; \$30 Copay OON (4 Visits Per Year) Podiatry: \$30 Copay IN; \$30 Copay OON (4 Visits Per Year)	Chiropractic: \$20 Copay IN; \$25 Copay OON (4 Visits Per Year) Podiatry: \$25 Copay IN; \$25 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)
	Formulary	Performance	Performance	Performance	Not Covered	Performance	Venture	Venture
Drug r D Drugs 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%	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%
Pag (U)	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 the	rough your retail pharmacy and through mail order) reaches \$6,350, you p  Copay for all other drugs.	ay 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 the	nrough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

munity Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may 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 Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

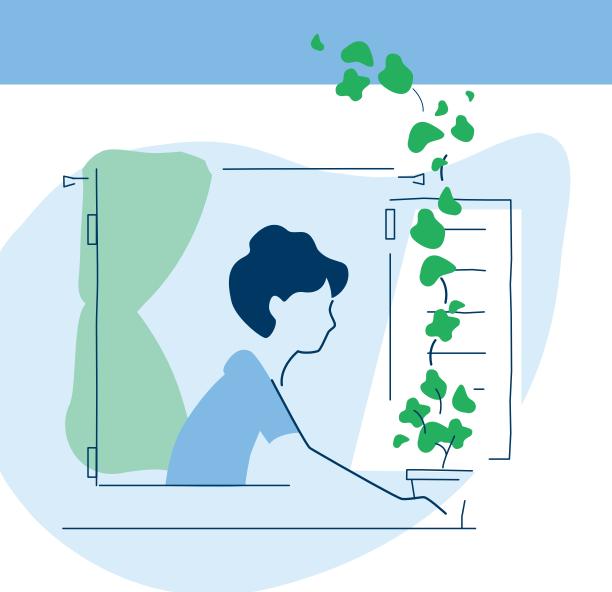
see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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

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

SilverSneakers program.

TruHearing is a registered trademark of TruHearing, Inc.









## 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.

# step 1



### **HOW IT WORKS:**

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

N = Out-of-Network	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
Monthly Plan Premium <sup>1</sup>	\$0	\$0	\$35	\$77	\$70	\$185.50	\$288.50
Out-of-Pocket Maximun	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
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
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/Urgen Care	t e e e e e e e e e e e e e e e e e e e	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent C	Care: \$50 Copay Emergenc	y: \$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)	\$0 Per Day (Days 1-20), \$178 Per Day (Days 21-100)		er Day (Days 1-20), \$178 Per Day (Days 21-100)	
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).	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 Month 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	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	benefit maximum applies to non-standard frames or a \$150 benefit	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).	benefit maximum applies to non-standard frames or a \$150 benefit	Exam: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyegla lenses and frames or contact lenses are covered in full. IN/OON: A \$1 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum 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)
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,	Preferred Retail: Tier 1: \$0, Tier 2: \$5, 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%
Tier 5: Specialty  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 Tier 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discoun Standard Retail: Generics: Tier 1 (\$5) Generics: Tier 2 (\$19) Generics Tier 3-5 (25% coinsurance) Brand (25% coinsurance including 70% discound
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased the	nrough your retail pharmacy and through mail order) reaches \$6,350, you pa Copay for all other drugs.	y 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 t	through your retail pharmacy and through mail order) reaches \$6,350, you properties through your retail pharmacy and through mail order) reaches \$6,350, you properties through your retail pharmacy and through mail order) reaches \$6,350, you properties through your retail pharmacy and through mail order) reaches \$6,350, you properties through your retail pharmacy and through mail order) reaches \$6,350, you properties through your retail pharmacy and through mail order.	pay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95

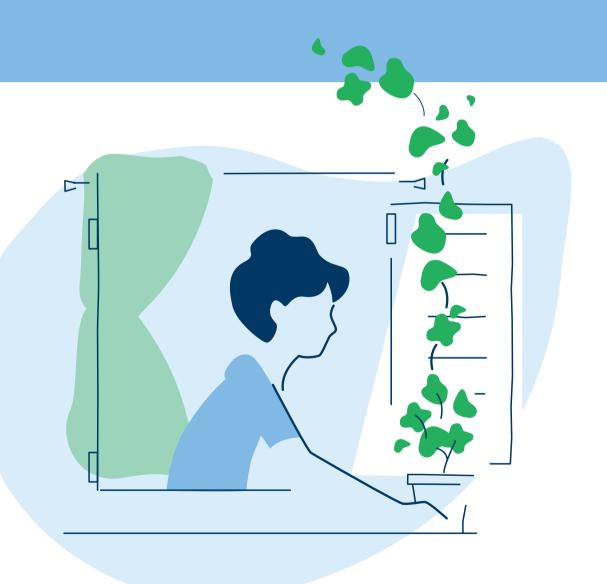
Commo	Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may vish to consider our Freedom Blue PPO Medicare Advantage products.				
	**Does not apply to all benefits across all plans.				
	This information is not a complete description of 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 Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.				

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SilverSneakers program.

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Medicare Plan Comparison Guide 2020 Covered Counties: Columbia, Montour, Northumberland



# The right plan for you.

## Guaranteed.

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# step 1



## **HOW IT WORKS:**

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

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

OON	OON = Out-of-Network		Freedom Blue PPO Basic	Freedom Blue PPO ValueRx	Freedom Blue PPO Standard	Freedom Blue PPO Deluxe	
	sic Costs	Monthly Plan Premium <sup>1</sup>	\$77	\$70	\$185.50	\$288.50	
	Bo	Out-of-Pocket Maximum	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	
	ی ⊒	Doctor Office Per Visit	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	
	Physicia Service	Lab & Diagnostic Tests	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	
	± S	X-rays/Advanced Imaging	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	
	S	Outpatient Surgery	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	
ج	ervice	Emergency Room/Urgent Care	Emergency: \$90 Copay; Urgent Care: \$50 Copay	Emergency: \$90 Copay; Urgent Care	e: \$50 Copay Emer	rgency: \$90 Copay; Urgent Care: \$50 Copay	
Health	scility S	Inpatient Hospital Stay	\$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	
	ъ	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 21-10	\$0 Per Day (Days 1-20), \$178 Per	Per Day (Days 21-100)	
		Routine Hearing (2 Hearing Aids 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)	
	nal ts	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).	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).	
	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 \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum	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		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	
		Routine Chiropractic/ Podiatry	for post cataract eyewear (once per operared eye).  Chiropractic: \$20 Copay IN; \$35 Copay OON (8 Visits Per Year)  Podiatry: \$35 Copay IN; \$35 Copay OON (10 Visits Per Year)	post cataract eyewear (once per operated eye).  Chiropractic: \$20 Copay IN; \$40 Copay OON (6 Visits Per Year)  Podiatry: \$40 Copay IN; \$40 Copay OON (8 Visits Per Year)	for post cataract eyewear (once per operated eye).  Chiropractic: \$20 Copay IN; \$35 Copay OON (8 Visits Per Year)  Podiatry: \$35 Copay IN; \$35 Copay OON (10 Visits Per Year)	post cataract eyewear (once per operated eye).  Chiropractic: \$20 Copay IN; \$30 Copay OON (10 Visits Per Year)  Podiatry: \$30 Copay IN; \$30 Copay OON (12 Visits Per Year)	
		Formulary	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	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%	
	<b>a</b> D	Coverage Gap	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	Not Covered	After your yearly out-of-pocket drug costs (including drugs purchased the	hrough your retail pharmacy and through mail order) reaches \$6,350, you p Copay for all other drugs.	bay the greater of: 5% of the cost, or \$3.60 Copay for generics and a \$8.95	

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

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