2021 Community Blue Medicare PPO Summary of Benefits

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

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

Residents of the following counties: Berks, Bradford, Columbia, Lackawanna, Luzerne, Montour, Northumberland, Pike, Snyder, Susquehanna, Union, Wayne, Wyoming **please click here.**

Residents of the following county: Lancaster, please click here.



CENTRAL AND NORTHEASTERN PENNSYLVANIA

Community Blue Medicare PPO

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Carbon, Lehigh, Monroe, Northampton and Schuylkill

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

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

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

How to Find a Provider or Pharmacy

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

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

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

More About Original Medicare

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

Out-Of-Network Benefit

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

Central and Northeastern Pennsylvania

	Community Blue Medicare PPO Distinct
Premium	\$35
Part B Premium	\$33
Reduction	\$0
Deductible	\$0
Max Out-Of-Pocket	\$6,500 IN; \$10,000 Catastrophic
Inpatient Hospital Stay	\$325 Copay Per Admit IN*; \$375 Copay Per Admit OON
Outpatient Hospital	ASC ¹ : \$225 Copay IN*; \$300 Copay OON
Coverage	Facility: \$275 Copay IN*; \$325 Copay OON
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	\$90 Copay IN/OON
Urgently Needed Services	\$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$40 Copay OON Outpatient: \$30 Copay IN*; \$40 Copay OON
X-Rays/ Advanced Imaging	X-ray: \$25 Copay IN*; \$40 Copay OON Advanced Imaging: \$285 Copay IN*; \$300 Copay OON
Hearing Services	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)
Dental Services	Medicare Covered: \$30 Copay IN; \$30 Copay OON. 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)
Vision Services	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$475 Copay/day (days 1-3), \$0 Copay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$50 Copay OON
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	\$25 Copay IN*; \$40 Copay OON
Ambulance (per one- way trip)	Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
отс	\$75 Allowance Once Per Quarter IN/OON
Routine Podiatry	\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary	Performance
,	

*Indicates a service that requires prior authorization.

Premium \$0	Community Blue Medicare PPO Signature
	0
Part B Premium Reduction	2
Deductible \$0	0
Max Out-Of-Pocket \$7	7,550 IN; \$10,000 Catastrophic
Inpatient Hospital Stay \$3	395 Copay Per Admit IN*; \$225 Copay/day (days 1-7), \$0 Copay/day (days 8-90) OON
Outpatient Hospital A	ASC ¹ : \$275 Copay IN*; \$425 Copay OON
Coverage Fa	acility: \$350 Copay IN*; \$425 Copay OON
LIOCTOR UTTICE VISIT	CP: \$0 Copay IN; \$0 Copay OON pecialist: \$35 Copay IN; \$35 Copay OON
Preventive/ Screening Co	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room \$9	90 Copay IN/OON
Urgently Needed \$5 Services	50 Copay IN/OON
Lah & Diagnostic Lests	Office/Lab: \$0 Copay IN*; \$35 Copay OON Dutpatient: \$30 Copay IN*; \$35 Copay OON
•	X-ray: \$35 Copay IN*; \$50 Copay OON
	Advanced Imaging: \$270 Copay IN*; \$370 Copay OON
	Aedicare Covered: \$35 Copay IN; \$35 Copay OON. Coutine: \$35 Copay IN; \$35 Copay OON (1 Per Year).
Hearing Services	YuHearing Advanced: \$699 Copay;
	Furthearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)
М	Iedicare Covered: \$35 Copay IN; \$35 Copay OON.
Dental Services	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months).
	X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)
	Aedicare Covered: \$35 Copay IN; \$35 Copay OON.
	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are
	overed in full. IN/OON: A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum
	or specialty contact lenses per year. 200 benefit maximum for post cataract eyewear (once per operated eye).
	npatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3), \$0
	Copay/day (days 4-90) OON
	Dutpatient: \$40 Copay IN*; \$60 Copay OON
Skilled Nursing Facility \$0	0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy \$4	40 Copay IN*; \$60 Copay OON
, i	mergent/Non-Emergent: \$295 Copay IN**;
	Ion-Emergent: 30% Coinsurance OON
•	0 Copay IN*; 30% Coinsurance OON
-	0% Coinsurance IN*; 30% Coinsurance OON
	75 Allowance Once Per Quarter IN/OON
-	35 Copay IN; \$35 Copay OON (4 Visits Per Year)
Durable Medical 20 Equipment	0% Coinsurance IN*; 30% Coinsurance OON
	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary Pe	erformance

*Indicates a service that requires prior authorization.

Community Blue Medicare PPO Distinct

D R U G

		Tier	31 Day Supply	90 Day Supply
	Standard Retail	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay
		Tier 2 (Generic)	\$15 Copay	\$45 Copay
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
		Tier	31 Day Supply	90 Day Supply
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Coverage		Tier	31 Day Supply	90 Day Supply
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred	Tier	31 Day Supply	90 Day Supply
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
				11
Coverage Gap	reaches \$4,130 and 25% of the). After you enter the coverage gap	ost (including what our plan has pa b, you pay 25% of the plan's cost f rugs until your costs total \$6,550,	id and what you have paid) for covered brand name drugs
Coverage Gap	reaches \$4,130 and 25% of the coverage gap.). After you enter the coverage gap e plan's cost for covered generic d	ost (including what our plan has pa b, you pay 25% of the plan's cost f rugs until your costs total \$6,550, age gap.	id and what you have paid) for covered brand name drugs
Coverage Gap Catastrophic Coverage	reaches \$4,130 and 25% of the coverage gap. Generics (25% After your yea	After you enter the coverage gap e plan's cost for covered generic d Not everyone will enter the cover o Coinsurance) Brand (25% Coinsur rly out-of-pocket drug costs (inclu- tiches \$6,550, you pay the greater of	ost (including what our plan has pa b, you pay 25% of the plan's cost f rugs until your costs total \$6,550, age gap.	id and what you have paid) for covered brand name drugs which is the end of the ur retail pharmacy and through

Community Blue Medicare PPO Signature

You pay the following until your total yearly drug costs reach \$4,130. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

		Tier	31 Day Supply	90 Day Supply		
	Standard	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay		
	Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay		
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
		Tier	31 Day Supply	90 Day Supply		
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay		
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay		
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay		
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage		Tier	31 Day Supply	90 Day Supply		
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay		
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay		
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Preferred	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay		
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay		
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.					
	Generics (25%	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)				
Catastrophic Coverage		aches \$6,550, you pay the greater	uding drugs purchased through yo of: 5% of the cost, or \$3.70 Copay			
	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others					

D R U G

HIGHMARK.

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

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

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

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

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

TruHearing is a registered trademark of TruHearing, Inc.



CENTRAL AND NORTHEASTERN PENNSYLVANIA

Community Blue Medicare PPO

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

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

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

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Out-Of-Network Benefit

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

Central and Northeastern Pennsylvania

Premium S0 Part B Permium S2 Reduction S2 Deductible S0 Max Out-Of-Poeket S1550 IN; \$10.000 Catastrophic Inpatient Hospital S355 Copay Per Admin IN*; \$225 Copay (DN Outpatient Hospital ASC: \$275 Copay IN*; \$425 Copay (ON Coverage Facility: \$350 Copay N*; \$425 Copay ON Preventive/Screening Coverage Correct in Full (Office visit Copay may apply) IN/ON Brenergeeny ROM S90 Copay IN/ON Urgently Needed S50 Copay IN*; \$355 Copay ON Services S90 Copay IN/ON Lab & Diagnostic Test Office/Lab: \$0 Copay IN*; \$355 Copay ON Acareed Imaging Correct is \$35 Copay IN*; \$35 Copay ON Advanced Traitering Perminm: \$90 Copay 2 Copay ON Advanced Traitering Perminm: \$90 Copay 2 Copay CON Advanced Services Reduction: \$35 Copay IN*; \$35 Copay ON Advanced Imaging Services Medicare Covered: \$35 Copay IN; \$35 Copay ON Medicare Covered: \$35 Copay IN; \$35 Copay ON Medicare Covered: \$35 Copay IN; \$35 Copay ON Medicare Covered: \$35 Copay IN; \$35 Copay ON Medicare Covered: \$35 Copay		Community Blue Medicare PPO Signature
Part B Premium Reduction\$2Deductible\$0Max Out-Of-Pocket\$7,550 IN; \$10,000 CatastrophicInpatient Hospital\$395 Copay Per Admit IN*; \$225 Copay/day (days 1-7), 50 Copay/day (days 8-90) OONOutpatient HospitalASC': \$275 Copay IN*; \$425 Copay OON Sciences Participy: \$350 Copay IN*; \$350 Copay OON Sciences Participy: \$350 Copay IN*; \$350 Copay OON Outgently NeededPreventive/ ScreeningCovered in Full (Office visit Copay IN*; 535 Copay OON Outgently NeededLab & Diagnostic TessOffice/Lai: \$30 Copay IN*; 535 Copay OON Advanced Imaging: \$270 Copay IN*; 535 Copay OON Advanced Imaging: \$270 Copay IN*; 535 Copay OON Routine: \$35 Copay IN*; 535 Copay OON Routin	Premium	
Max Out-Of-Pocket97,550 IN; 810,000 CatastrophieInpatient Hospital Stay5395 Copay Per Admin IN*; 5225 Copay ON Activ: 5357 Copay IN*; 5425 Copay ON CoverageOutpatient Hospital CoverageASC*: 5275 Copay IN*; 5425 Copay ON Speciality: 5350 Copay ON Speciality: 5351 Copay IN*; 5425 Copay ON Speciality: 5351 Copay IN*; 5425 Copay ON Speciality: 5351 Copay IN*; 5425 Copay ON Speciality: 5351 Copay IN*; 535 Copay ON Speciality: 5351 Copay IN*; 5351 Copay ON Speciality: 5351 Copay IN*; 5351 Copay ON Speciality: 5351 Copay IN*; 5351 Copay ON Copay IN*; 5301 Copay IN*; 5351 Copay ON Copay IN*; 5301 Copay IN*; 5351 Copay ON Copay IN*; 5351 Copay ON Advanced Imaging: 5270 Copay IN*; 5351 Copay ON Advanced Imaging: 5270 Copay IN*; 5351 Copay ON Advanced Imaging: 5270 Copay IN*; 5351 Copay ON Copay IN*; 5351 Copay ON Inthering Advanced: 535 Copay IN; 5351 Copay ON Copay IN*; 5351 Copay ON Comprehensive: 50% Coinsurance ON (I Per Year). TurtHearing Premium: 50% Coinsurance ON (I Per Year). Son ServicesDental ServicesKedicare Covered: 535 Copay IN; 535 Copay ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/adva (day S-400) ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/adva (day S-400) ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/adva (day S-400) ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/adva (day S-400) ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/adva (day S-400) ON Comprehensive: 50% Coinsurance ON (I Per Year). Son Copay/	Part B Premium	\$2
Inpatient Hospital StayS395 Copay Per Admit IN*, S225 Copay/day (days 1-7), S0 Copay/day (days 8-90) OONOutpatient HospitalASC ¹ : S275 Copay IN*, S425 Copay OON Facility: S350 Copay IN*, S0 Copay OON Specialist: S35 Copay IN*, S0 Copay OON Specialist: S35 Copay IN*, S0 Copay OON Outpatient S05 Copay IN*, S0 Copay OON Specialist: S35 Copay IN*, S0 Copay OON Outpatient S05 Copay IN*, S05 Copay OON Outpatient S06 Copay IN*, S05 Copay OON Outpatient: S00 Copay IN*, S05 Copay OON Aray: S05 Copay IN*, S05 Copay OON, Aray: S05 Copay IN*, S05 Copay OON, Intelaring Aranced: S09 Copay; IN*, S05 Copay OON, Intelaring Avanced: S05 Copay, IN*, S05 Copay OON, (Per Year), Trutlearing Avanced: S05 Copay, IN*, S05 Copay OON, Aray: S15 Copay IN*, S05 Copay OON, Intelaring Avanced: S05 Copay, IN*, S05 Copay OON, Aray: S15 Copay IN*, S05 Copay OON, Indicare Covered: S15 Copay, IN*, S05 Copay OON, Routine: S05 Copay IN*, S05 Copay OON, Indicare Covered: S15 Copay, IN*, S05 Copay OON, Routine: S00 Copay IN*, S05 Copay OON, I Per Year), S10 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum applies to non-standard frames or a s100 benefit maximum for p	Deductible	\$0
Outpatient Hospital CoverageASC!: \$275 Copay IN*; \$425 Copay OON Facility: \$350 Copay IN; \$350 Copay OON PCP-end/Specialis: \$350 Copay IN; \$350 Copay OON Specialis: \$350 Copay IN; \$350 Copay OON Preventive/ScreeningCovered in Full (Office visit Copay may apply) IN/OONPreventive/ScreeningCovered in Full (Office visit Copay may apply) IN/OONUrgently Needed\$90 Copay IN*; \$35 Copay OON Ompatient: \$300 Copay IN*; \$350 Copay OON Ompatient: \$300 Copay IN*; \$350 Copay OON Advanced ImagingLab & Diagnostic TestsOffice/Lab: \$00 Copay IN*; \$350 Copay OON Advanced Imaging: \$270 Copay IN*; \$350 Copay OON Advanced Imaging: \$270 Copay IN*; \$350 Copay OON Advanced Imaging: \$270 Copay IN*; \$350 Copay OON, Advanced Imaging: \$270 Copay IN*; \$350 Copay OON, Advanced Imaging: \$270 Copay IN*; \$350 Copay OON, Office/Lab: \$35 Copay IN; \$35 Copay OON, Condiciace Covered: \$35 Copay IN; \$35 Copay OON, Office Visit: \$15 Copay IN; \$35 Copay ON, Office Visit: \$15 Copay IN; \$35 Copay ON, IP PT Year). Comprehensive: \$96 Coinsurance ON (I PT Year). Comprehensive: \$96 Coinsurance ON, IP PT Year). Comprehensive: \$90 Copay IN*; \$90 Copay/day (day 2-1-00) IN*; \$90 Copay/da	Max Out-Of-Pocket	\$7,550 IN; \$10,000 Catastrophic
CoverageFacility: \$350 Copay IN; \$425 Copay OONDoctor Office Visit\$2CP: 50 Copay IN; \$50 Copay OON Speciality: \$35 Copay OON Speciality: \$35 Copay IN; \$50 Copay ON Speciality: \$35 Copay IN; \$50 Copay ON Speciality: \$35 Copay IN; \$50 Copay ON Speciality: \$35 Copay IN; \$50 Copay ON ONPreventive/ Screeni\$90 Copay IN/ONUrgently Needed\$50 Copay IN; \$50 Copay ON Speciality: \$35 Copay ON Outpatient: \$30 Copay IN*; \$35 Copay ON Outpatient: \$30 Copay IN*; \$35 Copay ON Advanced Imaging: \$270 Copay IN*; \$35 Copay ON Prevent: \$35 Copay IN; \$35 Copay ON, Trullearing Advanced: \$390 Copay; Calda Every Year IN; \$350 Allowance IN/OON (Per Year) Trullearing Advanced: \$390 Copay; Calda Every Year IN; \$350 Allowance IN/OON (Per Year) Trullearing Premium: \$999 Copay; Calda Every Year IN; \$350 Allowance IN/OON (Per Year) Comprehensive: \$90 Copay IN; \$35 Copay ON. Office Visit \$15 Copay IN; \$35 Copay ON. Office Visit \$15 Copay IN; \$35 Copay ON. Consurance ON (I Per Year). Trullearing Advanced: \$90 Consurance ON (I Per Year). Trullearing Advanced: \$90 Copay ON (I Per Year). Soude allowance IN/OON (Per Year). Soude enfit maximum for pot catarate gewear (once per operated eye). Soude enfit maximum for pot catarate gewear (once per operated eye). Soude enfit maximum for pot catarate gewear (once per operated eye). Soude enfit maximum for pot catarate gewear (once per operated eye). Sou	Inpatient Hospital Stay	\$395 Copay Per Admit IN*; \$225 Copay/day (days 1-7), \$0 Copay/day (days 8-90) OON
Doctor Office VisitPCP: 50 Copay IN; 50 Copay OON Specialist: 535 Copay IN; 535 Copay ONPreventive/ ScreeningCovered in Full (Office visit Copay may apply) IN/OONUrgently Needed ServicesS50 Copay IN/ONUrgently Needed ServicesOffice/Lab: 50 Copay IN*; 535 Copay OON Outpatient: 530 Copay IN*; 535 Copay OON Outpatient: 530 Copay IN*; 535 Copay OON Outpatient: 530 Copay IN*; 535 Copay OON Advanced Imaging: 5270 Copay IN*; 535 Copay OON Routine: 535 Copay IN*; 535 Copay OON, Routine: 535 Copay IN*; 535 Copay OON, Comprehensive: 50% Coinsurance OON (1 Per Year). Tratletaring Perinamic 5099 Copay; Tratletaring Perinamic 5099 Copay; Comprehensive: 50% Coinsurance OON (1 Per Six Months). X-Rays: 515 Copay IN; 535 Copay OON, Routine: 500 Copay IN*; 550 Co	Outpatient Hospital	ASC ¹ : \$275 Copay IN*; \$425 Copay OON
Doctor Ontice VisitSpecialist: \$35 Copay IN; \$35 Copay OONPreventive/ ScreeningCoverd in Full (Office visit Copay may apply) IN/ONEmergency Room\$90 Copay IN/ONVigrently Needed\$50 Copay IN/ONLab & Diagnostic TestOffice/Lab: \$00 Copay IN*; \$35 Copay ONVigrently Needed\$50 Copay IN*; \$35 Copay ONX-Rays/ AdvancedX-ray: \$35 Copay IN*; \$35 Copay ONX-Rays/ AdvancedX-ray: \$35 Copay IN*; \$35 Copay ONMedicare Covered: \$35 Copay IN*; \$35 Copay ONPearing ServicesRedicare Covered: \$35 Copay IN; \$35 Copay ON.Pearing ServicesMedicare Covered: \$35 Copay IN; \$35 Copay ON.Pental ServicesMedicare Covered: \$35 Copay IN; \$35 Copay ON.Optice Visit: \$15 Copay IN; \$35 Copay ON.Pental ServicesMedicare Covered: \$35 Copay IN; \$35 Copay ON.Optice Visit: \$15 Copay IN; \$39 Coinsurance ON (I Per Six Months). X-Rays: \$15 Copay IN; \$39 Coinsurance ON (I Per Six Months). X-Rays: \$15 Copay IN; \$30 Copay OON.Vision ServicesMedicare Covered: \$35 Copay IN; \$35 Copay ON.Vision ServicesRedicare Covered: \$35 Copay IN; \$35 Copay ON.Skilled Nursing FaelityNeutine: \$00 CopayiNay (days Coinsurance ON) (I Per Year). Source and the maximum for post catarate eyewar (once per operated eye).Skilled Nursing FaelitySource Intel Interviewar (once per operated eye).Skilled Nursing FaelitySource Intel Interviewar (once per operated eye).Skilled Nursing FaelitySource Interviewar (Source Por) Source operated eye).Skilled Nursing FaelitySource Interviewar (Source Por) In*; \$300 Copay/ady (days 1-3), \$00	Coverage	Facility: \$350 Copay IN*; \$425 Copay OON
Emergency Room890 Copay IN/OONUrgently Needed Services\$50 Copay IN/OONLab & Diagnostic TestsOffice/Lab: \$0 Copay IN*; \$35 Copay OON Outpatient: \$30 Copay IN*; \$35 Copay OON Advanced Imaging: \$270 Copay IN*; \$35 Copay OON Advanced Imaging: \$270 Copay IN*; \$35 Copay OON Advanced Imaging: \$270 Copay IN*; \$35 Copay OON Routine: \$35 Copay IN*; \$35 Copay OON Routine: \$35 Copay IN; \$35 Copay OON. Routine: \$35 Copay IN; \$35 Copay OON. Routine: \$35 Copay IN; \$35 Copay OON. Office Visit: \$15 Copay IN; \$35 Copay OON. Routine: \$00 copay IN; \$35 Copay OON. Outpatient: \$00 Copay IN; \$35 Copay OON. Outpatient: \$00 copay IN; \$35 Copay OON. Outpatient: \$00 copay IN; \$35 Copay OON. Intel and the anxinum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance OWN (I Per Year). Southers are covered in full. IN/OON: \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum a	Doctor Office Visit	
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ServicesSecopy INCONLab & Diagnostic TestsOffice/Lab: S0 Copay IN*; S35 Copay OON Outpatient: \$30 Copay IN*; S35 Copay OON Advanced Imaging: S270 Copay IN*; S37 Copay OON Advanced Imaging: S270 Copay IN*; S37 Copay OON Routine: S35 Copay IN*; S35 Copay OON. Routine: S35 Copay IN*; S35 Copay OON. Pertaing Premium: S999 Copay (2 Aids Every Year IN); S500 Allowance IN/OON (Per Year). TruHearing Advanced: S699 Copay. TruHearing Advanced: S50 Copay IN; S35 Copay OON. (Per Year). Comprehensive: S0% Coinsurance OON (1 Per Year). S000 enefit maximum for specially contact lenses preyea. S000 benefit maximum for specially contact lenses preyea. S000 Copay/day (days 1-3), S0 Copay/day (days 4-90) IN*; S00 Copay/day (days 1-3), S0 Copay/day (days 4-90) IN*; S00 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-100) IN*; S00 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/day (days 1-3), S0 Copay/	Emergency Room	\$90 Copay IN/OON
Lab & Diagnostic FestsOutpatient: \$30 Copay IN*; \$35 Copay OONX-Rays/ AdvancedX-ray: \$35 Copay IN*; \$50 Copay OON Advanced Imaging: \$270 Copay IN*; \$37 Copay OON Advanced Imaging: \$270 Copay IN*; \$35 Copay OON Advanced Imaging: \$270 Copay IN*; \$35 Copay OONHearing ServicesRoutine: \$35 Copay IN; \$35 Copay OON, TruHearing Premium: \$999 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year) TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)Dental ServicesMedicare Covered: \$35 Copay ON, \$35 Copay OON, Office Visit: \$15 Copay IN; 30% Coinsurance OON (I Per Year). Comprehensive: \$0% Copay IN; \$35 Copay ON, \$000 Copay OON, Office Visit: \$15 Copay IN; \$30 Copay OON, Outpatient: \$000 poor JN; \$50 Copay OON, Outpatient: \$000 poor JN; \$50 Copay OON, \$000 (I Per Year). Comprehensive: \$0% Coinsurance OON (I Per Year). Sond Copay IN; \$30 Copay OON, \$000 No Copay IN; \$30 Copay OON, \$100 benefit maximum \$2000 allowance IN/OON (Per Year) Sond Dentefit maximum \$2000 allowance IN/OON (Per Year)Mettal Health ServicesInpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$30% Coinsurance OON Outpatient: \$40 Copay IN*; \$60 Copay OON O		\$50 Copay IN/OON
ImagingAdvanced Imaging: \$270 Copay IN*; \$370 Copay OONHearing ServicesMedicare Covered: \$35 Copay IN; \$35 Copay OON. TruHearing Advanced: \$699 Copay; TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year). TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance OON (1 Per Year). Comprehensive: \$0% Coinsurance OON (1 Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year). Soutine: \$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 soctatare teyewear (once per operated eye).Medicare Covered: \$35 Copay IN; \$35 Copay OON (Aupstent: \$40 Copay IN*; \$60 Copay OON Outpatient: \$40 Copay IN*; \$60 Copay IN*; \$00 Copay/day (days 4-90) IN*; \$00 Copay/day (days 4-90) IN*; S00 Copay/day (days 4-90) IN*; \$00 Copay/day (days 4-90) IN*; \$00 Copay/day (days 4-90) IN*; \$00 Copay/day (days 4-90) IN*; S00 Copay/day (days 4-90) IN*; \$00 Copay IN*; \$00 Copay/day (days 4-90) IN*; \$00 Copay IN*; \$00 Copay/day (days 4-90) IN*; \$00 Consurance OON Tomaportati	Lab & Diagnostic Tests	
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Hearing ServicesRoutine: \$35 Copay IN; \$35 Copay OON (1 Per Year). TruHaering Advanced: \$609 Copay; TruHaering Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)Dental ServicesMedicare Covered: \$35 Copay IN; \$35 Copay OON. Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: \$0% Coinsurance With a maximum \$2,000 allowance IN/OON (Per Year)Vision ServicesMedicare Covered: \$35 Copay IN; \$35 Copay OON. Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for speci attaract eyewear (once per operated eye).Mental Health ServiceMotion: \$425 Copay (Augs 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-90) ON Cupatient: \$40 Copay IN*; \$60 Copay OON Cupatient: \$40 Copay IN*; \$60 Copay ON Cupatient: \$40 Copay IN*; \$60 Copa	Imaging	
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Vision ServicesRoutine: \$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).Mental Health ServicesInpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3), \$0 	Dental Services	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months). X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year).
Mental Health ServicesCopay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$60 Copay OONSkilled Nursing Facility\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OONPhysical Therapy\$40 Copay IN*; \$60 Copay OONAmbulance (per one- way trip)Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OONTransportation\$0 Copay IN*; 30% Coinsurance OONPart B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical 	Vision Services	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum for specialty contact lenses per year.
Physical Therapy\$40 Copay IN*; \$60 Copay OONAmbulance (per oneway trip)Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OONTransportation\$0 Copay IN*; 30% Coinsurance OONPart B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	Mental Health Services	Copay/day (days 4-90) OON
Ambulance (per one- way trip)Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OONTransportation\$0 Copay IN*; 30% Coinsurance OONPart B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
way trip)Non-Emergent: 30% Coinsurance OONTransportation\$0 Copay IN*; 30% Coinsurance OONPart B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	Physical Therapy	\$40 Copay IN*; \$60 Copay OON
Part B Drugs20% Coinsurance IN*; 30% Coinsurance OONOTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	u	
OTC\$75 Allowance Once Per Quarter IN/OONRoutine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	Transportation	\$0 Copay IN*; 30% Coinsurance OON
Routine Podiatry\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)Durable Medical Equipment20% Coinsurance IN*; 30% Coinsurance OON	Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
Durable Medical 20% Coinsurance IN*; 30% Coinsurance OON	OTC	\$75 Allowance Once Per Quarter IN/OON
Equipment 20% Coinsurance IN*; 30% Coinsurance OON	Routine Podiatry	\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)
Fitness Benefit Covered in Full IN: 50% Coinsurance after satisfying a \$500 Deductible OON		20% Coinsurance IN*; 30% Coinsurance OON
Covered in Fun 11, 50% Comsulate and Subsympting a \$500 beddelible Cort	Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary Performance	Formulary	Performance

*Indicates a service that requires prior authorization.

	Community Blue Medicare PPO Distinct
Premium	\$35
Part B Premium Reduction	\$0
Deductible	\$0
Max Out-Of-Pocket	\$6,500 IN; \$10,000 Catastrophic
Inpatient Hospital Stay	\$325 Copay Per Admit IN*; \$375 Copay Per Admit OON
Outpatient Hospital Coverage	ASC ¹ : \$225 Copay IN*; \$300 Copay OON Facility: \$275 Copay IN*; \$325 Copay OON
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	\$90 Copay IN/OON
Urgently Needed Services	\$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$40 Copay OON Outpatient: \$30 Copay IN*; \$40 Copay OON
X-Rays/ Advanced Imaging	X-ray: \$25 Copay IN*; \$40 Copay OON Advanced Imaging: \$285 Copay IN*; \$300 Copay OON
Hearing Services	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)
Dental Services	Medicare Covered: \$30 Copay IN; \$30 Copay OON. 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)
Vision Services	 Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$475 Copay/day (days 1-3), \$0 Copay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$50 Copay OON
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	\$25 Copay IN*; \$40 Copay OON
Ambulance (per one- way trip)	Emergent/Non-Emergent: \$295 Copay IN**; Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
OTC	\$75 Allowance Once Per Quarter IN/OON
Routine Podiatry	\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary	Performance

Community Blue Medicare PPO Signature

D R U G

	Standard Retail	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay	
		Tier 2 (Generic)	\$15 Copay	\$45 Copay	
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
		Tier	31 Day Supply	90 Day Supply	
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay	
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage		Tier	31 Day Supply	90 Day Supply	
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay	
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
	Preferred	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.				
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)				
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,550, you pay the greater of: 5% of the cost, or \$3.70 Copay for generics and a \$9.20 Copay for all other drugs.				
0.	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others				

Community Blue Medicare PPO Distinct

D R U G

		Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic)		\$21 Copay	
	Standard		\$7 Copay	1.1	
	Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay	
	Cost- Sharing	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	onanng	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
		Tier	31 Day Supply	90 Day Supply	
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay	
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage		Tier	31 Day Supply	90 Day Supply	
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay	
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
	Preferred	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.				
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)				
Catastrophic Coverage		ches \$6,550, you pay the greater	uding drugs purchased through yo of: 5% of the cost, or \$3.70 Copay		
	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others				



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

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

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

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

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

TruHearing is a registered trademark of TruHearing, Inc.



CENTRAL AND NORTHEASTERN PENNSYLVANIA

Community Blue Medicare PPO

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Berks, Bradford, Columbia, Lackawanna, Luzerne, Montour, Northumberland, Pike, Snyder, Susquehanna, Union, Wayne and Wyoming

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

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

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

How to Find a Provider or Pharmacy

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

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

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

More About Original Medicare

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

Out-Of-Network Benefit

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

Central and Northeastern Pennsylvania

	Community Blue Medicare PPO Signature
Premium	\$0
Part B Premium	
Reduction	\$2
Deductible	\$0
Max Out-Of-Pocket	\$7,550 IN; \$10,000 Catastrophic
Inpatient Hospital Stay	\$395 Copay Per Admit IN*; \$225 Copay/day (days 1-7), \$0 Copay/day (days 8-90) OON
Outpatient Hospital	ASC ¹ : \$275 Copay IN*; \$425 Copay OON
Coverage	Facility: \$350 Copay IN*; \$425 Copay OON
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$35 Copay IN; \$35 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	\$90 Copay IN/OON
Urgently Needed Services	\$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$35 Copay OON Outpatient: \$30 Copay IN*; \$35 Copay OON
X-Rays/ Advanced	X-ray: \$35 Copay IN*; \$50 Copay OON
Imaging	Advanced Imaging: \$270 Copay IN*; \$370 Copay OON
Hearing Services	Medicare Covered: \$35 Copay IN; \$35 Copay OON. Routine: \$35 Copay IN; \$35 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay;
	TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)
	Medicare Covered: \$35 Copay IN; \$35 Copay OON.
Dental Services	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months).
	X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)
	Medicare Covered: \$35 Copay IN; \$35 Copay OON.
Vision Services	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$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).
	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3),
Mental Health Services	\$0 Copay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$60 Copay OON
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	\$40 Copay IN*; \$60 Copay OON
Ambulance (per one- way trip)	Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
OTC	\$75 Allowance Once Per Quarter IN/OON
Routine Podiatry	\$35 Copay IN; \$35 Copay OON (4 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary	Performance

*Indicates a service that requires prior authorization.

	Community Blue Medicare PPO Distinct
Premium	\$35
Part B Premium Reduction	\$0
Deductible	\$0
Max Out-Of-Pocket	\$6,500 IN; \$10,000 Catastrophic
Inpatient Hospital Stay	\$325 Copay Per Admit IN*; \$375 Copay Per Admit OON
Outpatient Hospital	ASC ¹ : \$225 Copay IN*; \$300 Copay OON
Coverage	Facility: \$275 Copay IN*; \$325 Copay OON
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON
Emergency Room	\$90 Copay IN/OON
Urgently Needed Services	\$50 Copay IN/OON
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$40 Copay OON Outpatient: \$30 Copay IN*; \$40 Copay OON
X-Rays/ Advanced	X-ray: \$25 Copay IN*; \$40 Copay OON
Imaging	Advanced Imaging: \$285 Copay IN*; \$300 Copay OON
	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year).
Hearing Services	TruHearing Advanced: \$699 Copay;
	TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)
	Medicare Covered: \$30 Copay IN; \$30 Copay OON.
Dental Services	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Per Six Months).
	X-Rays: \$15 Copay IN; 30% Coinsurance OON (1 Per Year). Comprehensive: 50% Coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)
	Medicare Covered: \$30 Copay IN; \$30 Copay OON.
	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are
Vision Services	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).
	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$475 Copay/day (days 1-3),
Mental Health Services	\$0 Copay/day (days 4-90) OON
	Outpatient: \$40 Copay IN*; \$50 Copay OON
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON
Physical Therapy	\$25 Copay IN*; \$40 Copay OON
Ambulance (per one-	Emergent/Non-Emergent: \$295 Copay IN**;
way trip)	Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN*; 30% Coinsurance OON
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON
OTC	\$75 Allowance Once Per Quarter IN/OON
Routine Podiatry	\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Formulary	Performance

Community Blue Medicare PPO Signature

D R U G

		Tier	31 Day Supply	90 Day Supply	
	Standard	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay	
	Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay	
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
		Tier	31 Day Supply	90 Day Supply	
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay	
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage		Tier	31 Day Supply	90 Day Supply	
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay	
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
	Preferred	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay	
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay	
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay	
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable	
Coverage Gap	reaches \$4,130 and 25% of the	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.			
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)				
Catastrophic Coverage	mail order) rea	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,550, you pay the greater of: 5% of the cost, or \$3.70 Copay for generics and a \$9.20 Copay for all other drugs.			
Ū	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others				

Community Blue Medicare PPO Distinct

D R U

G

		Tier	31 Day Supply	90 Day Supply
	o	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay
	Standard Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
		Tier	31 Day Supply	90 Day Supply
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay
	Mail	Tier 2 (Generic)	Not Applicable	\$45 Copay
	Cost- Sharing	Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Coverage		Tier	31 Day Supply	90 Day Supply
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred	Tier	31 Day Supply	90 Day Supply
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
	Mail	Tier 2 (Generic)	Not Applicable	\$12 Copay
	Cost-	Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.			
	coverage gap.	Not everyone will enter the covera	age gap.	
		5 Coinsurance) Brand (25% Coinst		
Catastropic Coverage	Generics (25%) After your yea	o Coinsurance) Brand (25% Coinsurance) Brand (25% Coinsurance) rly out-of-pocket drug costs (inclu- tiches \$6,550, you pay the greater of	urance including 70% discount) Iding drugs purchased through you	



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

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

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

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TruHearing is a registered trademark of TruHearing, Inc.



CENTRAL PENNSYLVANIA

Community Blue Medicare PPO

Summary of Benefits

January 1, 2021 to December 31, 2021

The service area for these plans includes the following counties:

Lancaster

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

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

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

How to Find a Provider or Pharmacy

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

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

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

More About Original Medicare

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

Out-Of-Network Benefit

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

Central Pennsylvania

	Community Blue Medicare PPO Signature			
Premium	\$0			
Part B Premium	\$0			
Reduction	\$20			
Deductible	\$0			
Max Out-Of-Pocket	\$7,550 IN; \$10,000 Catastrophic			
Inpatient Hospital Stay	\$395 Copay Per Admit IN*; \$275 Copay/day (days 1-5), \$0 Copay/day (days 6-90) OON			
Outpatient Hospital	ASC ¹ : \$225 Copay IN*; \$450 Copay OON			
Coverage	Facility: \$350 Copay IN*; \$450 Copay OON			
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$30 Copay IN; \$30 Copay OON			
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON			
Emergency Room	\$90 Copay IN/OON			
Urgently Needed Services	\$50 Copay IN/OON			
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$50 Copay OON Outpatient: \$30 Copay IN*; \$50 Copay OON			
X-Rays/ Advanced	X-ray: \$20 Copay IN*; \$50 Copay OON			
Imaging	Advanced Imaging: \$295 Copay IN*; \$370 Copay OON			
	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Routine: \$30 Copay IN; \$30 Copay OON (1 Per Year).			
Hearing Services	TruHearing Advanced: \$699 Copay;			
	TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)			
	Medicare Covered: \$30 Copay IN; \$30 Copay OON. Office Visit: \$0 Copay IN; 30% Coinsurance OON (1 Per Six Months).			
Dental Services	X-Rays: \$0 Copay IN; 30% Coinsurance OON (1 Per Year).			
	Comprehensive: 50% Coinsurance with a maximum \$2,000 allowance IN/OON (Per Year)			
	Medicare Covered: \$30 Copay IN; \$30 Copay OON.			
Vision Services	Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames or a \$100 benefit maximum			
VISION SELVICES	for specialty contact lenses per year.			
	\$200 benefit maximum for post cataract eyewear (once per operated eye).			
	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$500 Copay/day (days 1-3),			
Mental Health Services	\$0 Copay/day (days 4-90) OON			
	Outpatient: \$40 Copay IN*; \$60 Copay OON			
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON			
Physical Therapy	\$30 Copay IN*; \$60 Copay OON			
Ambulance (per one- way trip)	Emergent/Non-Emergent: \$295 Copay IN**; Non-Emergent: 30% Coinsurance OON			
Transportation	\$0 Copay IN*; 30% Coinsurance OON			
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON			
OTC	\$75 Allowance Once Per Quarter IN/OON			
Routine Podiatry	\$30 Copay IN; \$30 Copay OON (4 Visits Per Year)			
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON			
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON			
Formulary	Performance			

*Indicates a service that requires prior authorization.

	Community Blue Medicare PPO Distinct				
Premium	\$35				
Part B Premium Reduction	\$0				
Deductible	\$0				
Max Out-Of-Pocket	\$6,500 IN; \$10,000 Catastrophic				
Inpatient Hospital Stay	\$275 Copay Per Admit IN*; \$325 Copay Per Admit OON				
Outpatient Hospital Coverage	ASC ¹ : \$200 Copay IN*; \$275 Copay OON Facility: \$275 Copay IN*; \$325 Copay OON				
Doctor Office Visit	PCP: \$0 Copay IN; \$0 Copay OON Specialist: \$25 Copay IN; \$25 Copay OON				
Preventive/ Screening	Covered in Full (Office visit Copay may apply) IN/OON				
Emergency Room	\$90 Copay IN/OON				
Urgently Needed Services	\$50 Copay IN/OON				
Lab & Diagnostic Tests	Office/Lab: \$0 Copay IN*; \$35 Copay OON Outpatient: \$30 Copay IN*; \$35 Copay OON				
X-Rays/ Advanced Imaging	X-ray: \$25 Copay IN*; \$35 Copay OON Advanced Imaging: \$205 Copay IN*; \$275 Copay OON				
Hearing Services	Medicare Covered: \$25 Copay IN; \$25 Copay OON. Routine: \$25 Copay IN; \$25 Copay OON (1 Per Year). TruHearing Advanced: \$699 Copay; TruHearing Premium: \$999 Copay (2 Aids Every Year IN); \$500 Allowance IN/OON (Per Year)				
Dental Services	Medicare Covered: \$25 Copay IN; \$25 Copay OON. 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)				
Vision Services	 Medicare Covered: \$25 Copay IN; \$25 Copay OON. Routine: \$0 Copay IN; \$50 Copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames or a \$150 benefit maximum for specialty contact lenses per year. \$200 benefit maximum for post cataract eyewear (once per operated eye). 				
Mental Health Services	Inpatient: \$425 Copay/day (days 1-3), \$0 Copay/day (days 4-90) IN*; \$475 Copay/day (days 1-3), \$0 Copay/day (days 4-90) OON Outpatient: \$40 Copay IN*; \$50 Copay OON				
Skilled Nursing Facility	\$0 Copay/day (days 1-20), \$184 Copay/day (days 21-100) IN*; 30% Coinsurance OON				
Physical Therapy	\$25 Copay IN*; \$35 Copay OON				
Ambulance (per one- way trip)	Emergent/Non-Emergent: \$295 Copay IN** Non-Emergent: 30% Coinsurance OON				
Transportation	\$0 Copay IN*; 30% Coinsurance OON				
Part B Drugs	20% Coinsurance IN*; 30% Coinsurance OON				
OTC	\$75 Allowance Once Per Quarter IN/OON				
Routine Podiatry	\$25 Copay IN; \$25 Copay OON (4 Visits Per Year)				
Durable Medical Equipment	20% Coinsurance IN*; 30% Coinsurance OON				
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON				
Formulary	Performance				

Community Blue Medicare PPO Signature

D R U G

	Standard Retail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay		
		Tier 2 (Generic)	\$15 Copay	\$45 Copay		
		Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
		Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Standard Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay		
		Tier 2 (Generic)	Not Applicable	\$45 Copay		
		Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay		
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay		
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage		Tier	31 Day Supply	90 Day Supply		
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay		
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay		
	Cost- Sharing	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
		Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Preferred Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay		
		Tier 2 (Generic)	Not Applicable	\$12 Copay		
		Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay		
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.					
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)					
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,550, you pay the greater of: 5% of the cost, or \$3.70 Copay for generics and a \$9.20 Copay for all other drugs.					
	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others					

Community Blue Medicare PPO Distinct

D R U

G

		Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay		
	Standard Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay		
	Cost-	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Standard Mail Cost-	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	Not Applicable	\$21 Copay		
		Tier 2 (Generic)	Not Applicable	\$45 Copay		
		Tier 3 (Preferred Brand)	Not Applicable	\$141 Copay		
	Sharing	Tier 4 (Non-Preferred Drug)	Not Applicable	\$300 Copay		
Initial		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage		Tier	31 Day Supply	90 Day Supply		
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay		
	Retail	Tier 2 (Generic)	\$5 Copay	\$15 Copay		
	Cost- Sharing	Tier 3 (Preferred Brand)	\$47 Copay	\$141 Copay		
		Tier 4 (Non-Preferred Drug)	\$100 Copay	\$300 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
	Preferred Mail Cost- Sharing	Tier	31 Day Supply	90 Day Supply		
		Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay		
		Tier 2 (Generic)	Not Applicable	\$12 Copay		
		Tier 3 (Preferred Brand)	Not Applicable	\$120 Copay		
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$275 Copay		
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable		
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.					
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)					
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,550, you pay the greater of: 5% of the cost, or \$3.70 Copay for generics and a \$9.20 Copay for all other drugs.					
	Greater of: 5% or \$3.70 Generic / Preferred Multi-Source or \$9.20 for all others					



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

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

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

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

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

TruHearing is a registered trademark of TruHearing, Inc.