Community Blue Medicare HMO

Summary of Benefits

January 1, 2018 – December 31, 2018

Service Area

Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington, and Westmoreland.

To join Community Blue Medicare HMO Signature or Community Blue Medicare HMO Prestige, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

This document is available in other formats such as Braille and large print.

How to Contact

CALL COMMUNITY BLUE MEDICARE HMO

1-866-687-3182 (TTY users can call 711), 8:00 a.m.– 8:00 p.m., 7 days a week

OR VISIT

www.highmarkblueshield.com/medicare

How to Find a Provider or Pharmacy

Community Blue Medicare HMO Signature and Community Blue Medicare HMO Prestige have 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 www.highmarkblueshield.com/medicare.

Or, call us and we will 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, client.formularynavigator.com/clients/hm/default.html.

Or, call us and we will send you a copy of the formulary.

Community Blue Medicare HMO Network: Community Blue Medicare HMO Signature and Community Blue Medicare HMO Prestige have a High Value Provider Network.

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

Please verify that your providers are participating before enrolling. If a provider does not participate, neither Medicare nor Community Blue Medicare HMO will be responsible for the costs.

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.

Every Highmark Medicare Advantage Plan Includes:

SILVERSNEAKERS® GYM MEMBERSHIP
Gives you access to over 13,000 participating facilities nationwide –with cardio and weight equipment, pools, saunas, and more.

HIGHMARK HOUSE CALL PROGRAM
Offers a free preventive health assessment, provided by a certified nurse practitioner, in the comfort of your own home.

ANNUAL WELLNESS VISIT
Encourages you to talk with your doctor about your overall health and to create a personal prevention plan for the year.

BLUES ON CALL
Provides 24/7 access to a registered nurse who can help you understand a diagnosis, review your symptoms, and much more.

Western Pennsylvania		Community Blue Medicare HMO Signature	Community Blue Medicare HMO Prestige
HEALTH	**Premium[1]**	$0	$197
	Medicare Part B Premium Reduction	$5	N/A
	Deductible	$0	$0
	Network Max Out-Of-Pocket	$6,700	$6,700
	Inpatient Hospital Stay	$275 Per Day (Days 1-5) Per Admit	$100 Per Admit
	Outpatient Hospital Coverage	ASC: $275 Copay Facility: $350 Copay	ASC: $50 Copay Facility: $50 Copay
	Doctor Office Visit	PCP: $0 Per Visit, Specialist: $40 Per Visit	PCP: $0 Per Visit, Specialist: $10 Per Visit
	Preventive/Screening	Covered in Full (Office visit Copay may apply)	
	Emergency Room	$80 Copay	$80 Copay
	Urgently Needed Services	$50 Copay	$50 Copay
	Lab & Diagnostic Tests	Office/Lab: $0 Copay, Outpatient: $25 Copay	Office/Lab: $0 Copay, Outpatient: $10 Copay
	X-Rays/Advanced Imaging	X-ray: $50 Copay, Advanced Imaging: $270 Copay	X-ray: $10 Copay, Advanced Imaging: $75 Copay
	Routine Hearing Aids (Exam annually) ***(2 hearing aids per year)***	$40 Copay for routine hearing exam TruHearing Enhanced: $699 Copay Per Aid; TruHearing Premium $999 Copay Per Aid	$10 Copay for routine hearing exam TruHearing Enhanced: $499 Copay Per Aid; TruHearing Premium $799 Copay Per Aid
	Routine Dental	Office Visit: $30 Copay (Every 6 Months); X-ray: $25 Copay (Per Calendar Year)	Office Visit: $20 Copay (Every 6 Months); X-ray: $20 Copay (Every 6 Months)
	Routine Vision ***(annually)***	$0 Copay for routine eye exam. Standard Eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.	
	Mental Health Services	Inpatient: $275 Per Day (Days 1-5) Per Admit Outpatient: $40 Copay	Inpatient: $100 Per Admit Outpatient: $10 Copay
	Skilled Nursing Facility ***(days 1-100 per benefit period/admit)***	$0 Per Day (Days 1-20), $167.50 Per Day (Days 21-100)	$0 Per Day (Days 1-20), $167.50 Per Day (Days 21-100)
	Physical Therapy	$40 Copay	$10 Copay
	Ambulance ***(per one-way trip)***	$350 Copay	$150 Copay
	Transportation ***(up-to 24 one-way trips)***	$10 Copay	$10 Copay
	Routine Podiatry	$40 Copay (4 visits)	$10 Copay (10 visits)
	Durable Medical Equipment ***(including oxygen)***	20% Coinsurance	20% Coinsurance
	Wellness Programs	SilverSneakers	SilverSneakers
	Part B Drugs	20% Coinsurance	20% Coinsurance
	Formulary	Choice	Venture

Community Blue Medicare HMO Signature

DRUG

You pay the following until your total yearly drug costs reach $3,750.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$20 Copay	$60 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 Offered

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$15 Copay	$15 Copay
Tier 2 (Generic)	$60 Copay	$60 Copay
Tier 3 (Preferred Brand)	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$40 Copay	$40 Copay
Tier 3 (Preferred Brand)	$115 Copay	$115 Copay
Tier 4 (Non-Preferred Drug)	$270 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (44% Coinsurance) Brand (35% Coinsurance including 50% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs
(including drugs purchased through your retail pharmacy and through mail order) reaches $5,000,
you pay the greater of: 5% of the cost, or $3.35 Copay for generics and a $8.35 Copayment for all other drugs.

Greater of: 5% or $3.35 Generic / Preferred Multi-Source or $8.35 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Additional Plan Benefits Continued on Next Page

Western Pennsylvania

Community Blue Medicare HMO Prestige

DRUG

You pay the following until your total yearly drug costs reach $3,750.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$20 Copay	$60 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 Offered

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$15 Copay	$15 Copay
Tier 2 (Generic)	$60 Copay	$60 Copay
Tier 3 (Preferred Brand)	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$40 Copay	$40 Copay
Tier 3 (Preferred Brand)	$115 Copay	$115 Copay
Tier 4 (Non-Preferred Drug)	$270 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table on Next Page

Catastrophic Coverage

After your yearly out-of-pocket drug costs
(including drugs purchased through your retail pharmacy and through mail order) reaches $5,000,
you pay the greater of: 5% of the cost, or $3.35 Copay for generics and a $8.35 Copayment for all other drugs.

Greater of: 5% or $3.35 Generic / Preferred Multi-Source or $8.35 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

COMMUNITY BLUE MEDICARE HMO PRESTIGE COVERAGE GAP TABLE			
Coverage Gap	**Preferred Retail**	**Tier**	
		Tier 1 Generics	$0 Copay
		Tier 2 Generics	$15 Copay
		Tiers 3-5 Generics	44% Coinsurance
		Brand	35% Coinsurance including 50% discount
	Standard Retail	**Tier**	
		Tier 1 Generics	$5 Copay
		Tier 2 Generics	$20 Copay
		Tiers 3-5 Generics	44% Coinsurance
		Brand	35% Coinsurance including 50% discount

[1]You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Limitations, Copayments, and restrictions may apply. Benefits, premiums and/or Co-payments/Co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.

Not all providers will accept Community Blue Medicare HMO. Please verify that your providers are participating before enrolling. If a provider does not participate, neither Medicare nor Community Blue Medicare HMO will be responsible for the costs. You must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers, neither Medicare nor Community Blue Medicare HMO will be responsible for the costs.

TruHearing is a registered trademark of TruHearing, Inc.

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

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-844-679-6930 uffrufe.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930 .

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો.

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ ការហៅ 1-844-679-6930 ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930 .

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-844-679-6930 پر کال کریں۔

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-844-679-6930 पर फ़ोन करें.

గమనిక: మీరు తెలుగు మాట్లాడితే, లాగ్వేజ్ అసెస్టెన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-844-679-6930.

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u.
Bel 1-844-679-6930.

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทร 1-844-679-6930

ध्यान दिनुहोस्: यदि तपाईं [नेपाली] भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू नि:शुल्क उपलब्ध हुन्छन्। 1-844-679-6930 मा फोन गर्नुहोस्।