HIGHMARK

WEST CENTRAL PENNSYLVANIA

Complete Blue PPO

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

Bedford, Blair, Cameron, Clarion, Clearfield, Elk, Huntingdon, Jefferson, Somerset

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

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

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WEST CENTRAL PENNSYLVANIA

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

How to Find a Provider or Pharmacy

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

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

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

More About Original Medicare

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

Out-Of-Network Benefit

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

	Complete Blue PPO Signature
Premium	$0.00
Part B Premium Reduction	$4.00
Deductible	$0
Max Out-Of-Pocket	$7,550 IN; $10,000 combined IN and OON
Inpatient Hospital Stay	Days 1 - 3: $150 copay per day per admit & Days 4 - 90: $0 copay per day per admit IN*; Days 1 - 3: $300 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON
Outpatient Hospital Coverage	ASC[1]: $195 copay IN*; $325 copay OON Facility: $245 copay IN*; $375 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	$95 copay IN/OON
Urgently Needed Services	$50 copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 copay IN*; $25 copay OON Outpatient: $0 copay IN*; $25 copay OON
X-Rays/ Advanced Imaging	X-ray: $20 copay IN*; $35 copay OON Advanced Imaging: $195 copay IN*; $325 copay OON
Hearing Services	Medicare Covered: $25 copay IN; $25 copay OON. Routine: $25 copay IN; $25 copay OON (1 Per Year). (2 Aids Every Year IN); $500 allowance IN/OON (per year) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay
Dental Services	Medicare Covered: $25 copay IN; $25 copay OON. Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $15 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance with a maximum $2,500 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 max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay per day per admit IN*; Days 1 - 3: $475 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON; Outpatient: $40 copay IN*; $50 copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$20 copay IN*; $35 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	$0 copay IN*; 30% coinsurance OON
Part B Drugs[†]	20% coinsurance IN*; 30% coinsurance OON
OTC	$100 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	Silver Sneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Performance

	Complete Blue PPO Distinct
Premium	$25.00
Part B Premium Reduction	$0.00
Deductible	$0
Max Out-Of-Pocket	$6,500 IN; $10,000 combined IN and OON
Inpatient Hospital Stay	$225 copay per admit IN*; $225 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $175 copay IN*; $175 copay OON Facility: $200 copay IN*; $200 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $10 copay IN; $10 copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Emergency Room	$95 copay IN/OON
Urgently Needed Services	$30 copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 copay IN*; $0 copay OON Outpatient: $0 copay IN*; $0 copay OON
X-Rays/ Advanced Imaging	X-ray: $20 copay IN*; $20 copay OON Advanced Imaging: $175 copay IN*; $175 copay OON
Hearing Services	Medicare Covered: $10 copay IN; $10 copay OON. Routine: $10 copay IN; $10 copay OON (1 Per Year). (2 Aids Every Year IN); $500 allowance IN/OON (per year) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay
Dental Services	Medicare Covered: $10 copay IN; $10 copay OON. Office Visit: $0 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 50% coinsurance with a maximum $3,000 allowance IN/OON (Per Year)
Vision Services	Medicare Covered: $10 copay IN; $10 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay per day per admit IN*; Days 1 - 3: $475 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON; Outpatient: $40 copay IN*; $40 copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$5 copay IN*; $5 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	$0 copay IN*; 30% coinsurance OON
Part B Drugs[†]	20% coinsurance IN*; 30% coinsurance OON
OTC	$145 allowance once per quarter IN/OON
Routine Podiatry	$10 copay IN; $10 copay OON (4 visits per year)
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON
Fitness Benefit	Silver Sneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Performance

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips. ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. After 7/1/2023, Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Complete Blue PPO Signature

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$0 Copay	$0 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$15 Copay	$45 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 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	$0 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$275 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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.			
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 for all others			

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

Complete Blue PPO Distinct

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$0			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$0 Copay	$0 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$20 Copay	$60 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 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	$0 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$280 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	$60 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs.			
	Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 for all others			

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

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

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

Out-of-network/non-contracted providers are under no obligation to treat Complete Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-833-544-1060 (TTY users may call 711) for more information.