



CENTRAL AND NORTHEASTERN PENNSYLVANIA

Community Blue Medicare PPO

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

**Berks, Bradford, Columbia, Lackawanna, Luzerne, Montour,
Northumberland, Pike, Snyder, Susquehanna, Union, Wayne,
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](https://www.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-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."

Community Blue Medicare PPO Distinct

| | |
|------------------------------|--|
| Premium | \$25.00 |
| Part B Premium Reduction | \$0.00 |
| Deductible | \$0 |
| Max Out-Of-Pocket | \$6,000 IN; \$8,950 combined IN and OON |
| Inpatient Hospital Stay | \$200 copay per admit IN*; \$200 copay per admit OON |
| Outpatient Hospital Coverage | ASC ¹ : \$175 copay IN*; \$175 copay OON Facility: \$245 copay IN*; \$245 copay OON |
| Doctor Office Visit | PCP: \$0 copay IN; \$0 copay OON Specialist: \$20 copay IN; \$20 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: \$20 copay IN; \$20 copay OON. Routine: \$20 copay IN; \$20 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: \$20 copay IN; \$20 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 \$3,000 allowance IN/OON (Per Year) |
| Vision Services | Medicare Covered: \$20 copay IN; \$20 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: \$425 copay per day per admit & Days 4 - 90: \$0 copay per day per admit OON; Outpatient: \$30 copay IN*; \$30 copay OON |
| Skilled Nursing Facility | \$0 copay/day (days 1-20), \$196 copay/day (days 21-100) IN*; 30% coinsurance OON |
| Physical Therapy | \$15 copay IN*; \$15 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: \$250 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 | \$20 copay IN; \$20 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.

ASC¹=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.

Community Blue Medicare PPO Distinct

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) | \$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 | | | |

DRUG

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 Shield provides certain administrative communications for this company. Highmark 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 Community Blue Medicare 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 1-844-785-1787 (TTY users may call 711) for more information.

TruHearing is a registered trademark of TruHearing, Inc.

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