HIGHMARK

CENTRAL AND NORTHEASTERN PENNSYLVANIA

Community Blue Medicare HMO

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

Berks, Bradford, Lackawanna, Luzerne, 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 HMO, call 1-866-687-3182 (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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CENTRAL AND NORTHEASTERN 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

Community Blue Medicare HMO 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.

	Community Blue Medicare HMO Signature
Premium	$0.00
Part B Premium Reduction	$4.00
Deductible	$0
Max Out-Of-Pocket	$6,700
Inpatient Hospital Stay*	$250 copay per admit
Outpatient Hospital Coverage*	ASC[1]: $125 copay Facility: $175 copay
Doctor Office Visit	PCP: $0 copay Specialist: $0 copay
Preventive/Screening	Covered in Full (Office visit copay may apply)
Emergency Room	$95 copay
Urgently Needed Services	$0 copay
Lab & Diagnostic Tests*	Office/Lab: $0 copay Outpatient: $0 copay
X-Rays*/ Advanced Imaging*	X-ray: $25 copay Advanced Imaging: $225 copay
Hearing Services	Medicare Covered: $0 copay. Routine: $0 copay (1 Per Year). (2 Aids Every Year) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay
Dental Services	Medicare Covered: $0 copay. Office Visit: $0; X-rays: $0.
Vision Services	Medicare Covered: $0 copay. $200 benefit max for post cataract eyewear (once per operated eye) Routine Office: $0 Copay (1 Every Year). Standard Eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses.
Mental Health Services*	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay per day per admit; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $196 copay/day (days 21-100)
Physical Therapy*	$20 copay
Ambulance (per one-way trip)**	Emergent/Non-Emergent: $250 copay
Transportation*	$0 copay
Part B Drugs*†	20% coinsurance
OTC	$25 allowance once per quarter
Routine Podiatry	$0 copay (4 visits per year)
Durable Medical Equipment*	20% coinsurance
Fitness Benefit	Covered in full
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.

Community Blue Medicare HMO Signature

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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)	$5 Copay	$15 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	$12 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.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal.

Health benefits or health benefit administration may be provided by or through Highmark Choice Company. Highmark Blue Shield provides certain administrative communications for this company. Highmark Blue Shield and Highmark Choice 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.

This information is not a complete description of benefits. Call 1-866-687-3182 (TTY users may call 711) for more information.