2025

Highmark Medicare Advantage, D–SNP, and ACA Individual Market Agent Product Guide



Contents

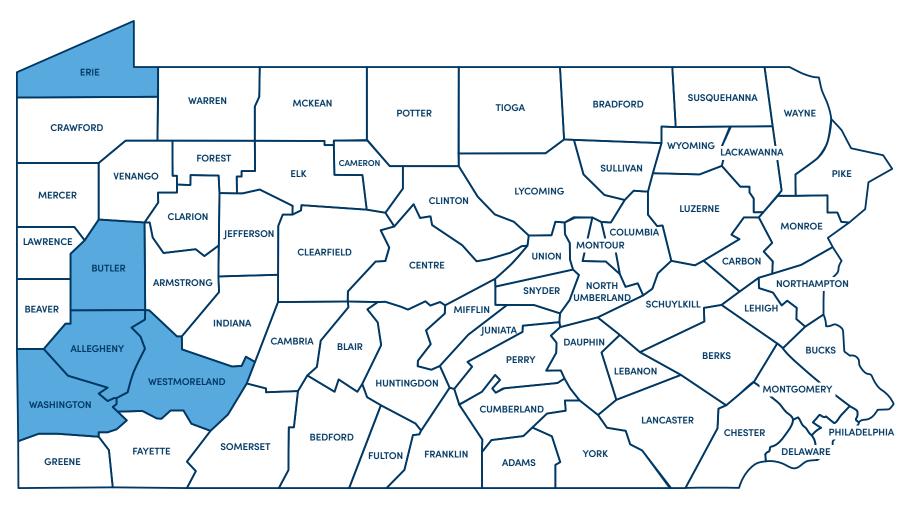
Medicare Advantage	3
WPA	4
CPA/NEPA	18
SEPA	34
WV	37
DE	44
WNY	47
NENY	57
D-SNP	69
PA	70
DE	72
ACA Individual Market	77
WPA	78
CPA	84
NEPA	90
SEPA	96
WV	102
DE	108
NENY	115
WNY	120

PRODUCTS AND PRICING BY COUNTY

Medicare Advantage

For Agent Use Only

Together Blue Medicare HMO — WPA



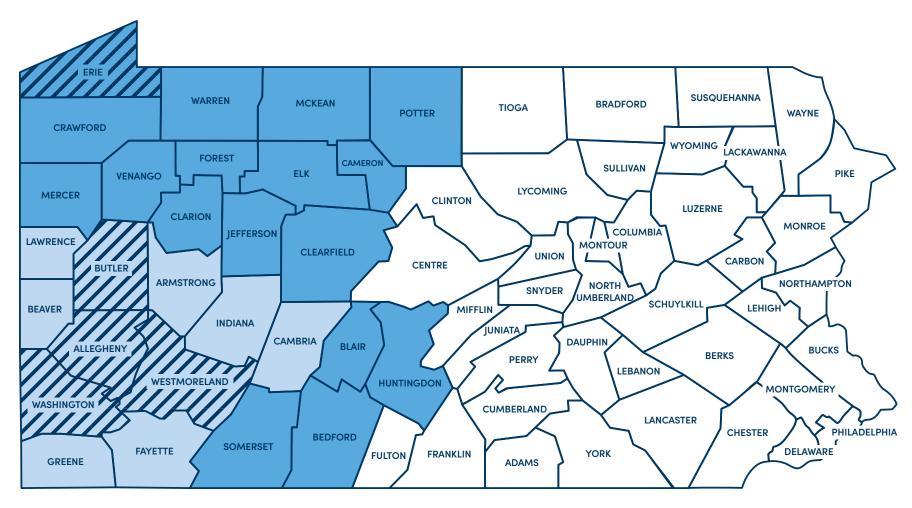
Together Blue Medicare HMO

Together Blue Medicare HMO — WPA (Products and pricing by county)

	SIGNATURE
Monthly Plan Premium	SO SO
Part B Premium Buyback	\$37 \$37
Out-of-Pocket Maximum	Network: \$4,900; Combined: N/A
PCP Office Visit	\$0 Copay
Specialist Office Visit	\$0 Copay
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay
X-rays	\$0 Copay
Radiation Therapy	\$60 Copay
Advanced Imaging	\$95 Copay
Preventive/Screening Outpatient Physical and Speech Therapy	Covered in Full (Office visit copay may apply) \$0 Copay
Medicare Covered Acupuncture	su Copay 90 Copay
Outpatient Occupational Therapy	30 CUPUY \$20 Copay
Outpatient Mental Health	\$30 Copay
Outpatient Substance Abuse	\$30 Copay
Outpatient Surgical	ASC: \$95 Copay; Facility: \$155 Copay
Ambulance	\$215 Copay
Transportation	\$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	\$125 Copay
Urgent Care	\$30 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$200/admit
Inpatient Psychiatry Stay	\$325/day (days 1 – 3), \$0/day (days 4 – 90)
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100)
Home Health	\$0 Copay
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom,
	20% coinsurance for all other covered diabetic supplies
Durable Medical Equipment	20% Coinsurance IN. Healing at Home: \$0 cost-share for DME up to a \$1,000 allowance once per calendar year
отс	Covered in Flex Card benefit
Flex Card	\$650 Dental, Vision, Hearing, OTC
Meal Benefit	N/A
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips IN
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs.
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments.
Fitness Benefit	32 credits per month; no rollover of credits
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs
Part B Drugs — Insulin Medicare Covered Vision (Office Visit)	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin \$0 Copay
Routine Vision (Office Visit)	su Copay \$0 Copay (One every year)
Routine Vision (Eyewear)	Standard Eyealass 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. \$200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	\$0 Copay \$0 Copay (One every year)
Routine Hearing Exam Routine Hearing (Hearing Aids)	su Copay (one every year) Two Hearing Aids every year; TruHearing Advanced – \$699 copay; TruHearing Premium – \$999 copay
Routine Dental	Office Visit: \$0 Copay (One every six months) Includes exam, cleaning, and fluoride treatment
Medicare Covered Comprehensive Dental	X-ray: \$0 Copay (One every year) \$0 Copay
Dental Allowance — Preventive and/or Comprehensive	Success Combined maximum allowance of \$3,000
Comprehensive Dental – Supplemental	\$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. See EOC for benefit limits.
Medicare Covered Chiropractic	SEE COUNTY DETERMINES. \$15 Coppy
Routine Chiropractic	S15 Copy (four visits)
Medicare Covered Podiatry	\$0 Copay
Routine Podiatry	\$0 Copay (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 Copay
	PART D DRUGS
Formulary	Lean (Performance)
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply.	
Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 18%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 18%, Tier 4: 50%, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up	Prefered Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 18%, Tier 4: 50%, Tier 5: 33%
to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: 18%, Tier 4: 50%, Tier 5: 33%
OOP Threshold	\$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

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Community Blue Medicare HMO — WPA





Community Blue Medicare HMO Southwest



Community Blue Medicare HMO West Central



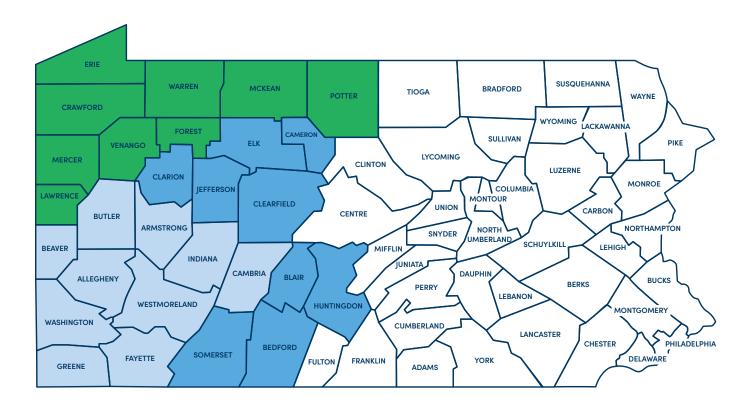
Community Blue Medicare HMO Greater Allegheny/Erie

^{*}Pricing is subject to CMS approval

Community Blue Medicare HMO - WPA (Products and pricing by county)

	SIGNATURE	PRESTIGE		
Monthly Plan Premium	SW/WC/OW: \$0	SW: \$35		
Part B Premium Buyback	SW: \$7; WC/GAE: \$6	\$3		
Out-of-Pocket Maximum	Network: SW/WC: \$5,500; OW: \$6,200; Combined: N/A	Network: \$5,500; Combined: N/A		
PCP Office Visit	\$0 Copay	\$0 Copay		
Specialist Office Visit	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay		
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay	\$0 Copay		
Lab and Diagnostic Tests (Outpatient Facility)	SW/WC: \$0 Copay; OW: \$30 Copay	\$0 Copay		
X-rays	\$20 Copay	\$20 Copay		
Radiation Therapy	\$60 Copay	\$50 Copay		
Advanced Imaging	\$195 Copay	\$95 Copay		
Preventive/Screening		visit copay may apply)		
Outpatient Physical and Speech Therapy	SW/WC: \$20 Copay; OW: \$30 Copay	\$10 Copay		
Medicare Covered Acupuncture	\$W/WC: \$20 Copay; OW: \$30 Copay	\$10 Copay		
Outpatient Occupational Therapy	SW/WC: \$20 Copay; OW: \$30 Copay	\$10 Copay		
Outpatient Mental Health Outpatient Substance Abuse	\$40 Copay \$45 Copay	\$30 Copay \$30 Copay		
Outpatient Surgical	ASC: SW/WC: \$175 Copay; OW: \$195 Copay; Facility: \$245 Copay	ASC: \$75 Copay; Facility: \$150 Copay		
Ambulance	SW/WC: \$255 Copay; OW: \$250 Copay	\$250 Copay		
Transportation		ntinued acute care after discharge from ER.		
Emergency Room		Copay		
Urgent Care	\$50 Copay	\$20 Copay		
Inpatient Hospital Stay	SW/WC: \$250/admit; OW: \$295/admit	\$200/admit		
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90)	\$225/admit		
Skilled Nursing Facility		214/day (days 21 – 100)		
Home Health	\$0 C	opay		
Diabetic Supplies and Services		obott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose		
		imited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies		
Durable Medical Equipment	20% Coinsurance IN	20% Coinsurance		
	Healing at Home (SW/GAE ONLY): \$0 cost-share for DME up to a \$1,000 allowance once	Healing at Home: \$0 cost-share for DME up to a \$1,000 allowance once per calendar		
отс	per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only SW: \$210 Allowance Once Per Quarter; WC: \$220 Allowance Once Per Quarter;	year upon Discharge from Inpatient Acute Hospital or SNF. IN Only		
OIC	GAE: \$180 Allowance Once Per Quarter;	\$180 Allowance Once Per Quarter		
Flex Card	N/A	N/A		
Onduo		ocrinologist and receive a glucometer with an unlimited supply of test strips IN		
Spring Health		nd virtual clinical support to help members address behavioral health needs.		
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments.			
Health care Kits	N/A	N/A		
Fitness Benefit		; no rollover of credits		
Additional Telehealth Services		ble Copay listed for outpatient		
Part B Drugs — Chemotherapy and All Other Part B		igs and 20% Coinsurance for all other Part B drugs		
Part B Drugs — Insulin		35 copay for a one month supply of insulin		
Medicare Covered Vision (Office Visit)	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay		
Routine Vision (Office Visit)	\$0 Copay (O	ne every year)		
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full.	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. \$200 benefit maximum for post cataract eyewear. IN	A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear. IN		
Medicare Covered Hearing Exam	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay		
Routine Hearing Exam	SW/WC: \$20 Copay (One every year); OW: \$25 Copay (One every year)	\$0 Copay (One every year)		
Routine Hearing (Hearing Aids)	Two Hearing Aids every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay	Two Hearing Aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay		
Routine Dental	Office Visit: \$0 Copay (One every six months) Includes exam, cleaning, and fluoride treatment; X-ray: \$0 Copay (One every year)	Office Visit: \$0 Copay (One every six months) Includes exam, cleaning, and fluoride treatment; X-ray: \$0 Copay (One every year)		
Medicare Covered Comprehensive Dental	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay		
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000	Combined maximum allowance of \$3,500		
Comprehensive Dental — Supplemental	\$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (re	movable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services.		
Medicare Covered Chiropractic	SW/WC: \$20 Copay; OW: \$15 Copay	benefit limits. \$10 Copay		
Routine Chiropractic	SW/WC: \$20 Copay (four visits); OW: \$15 Copay (four visits)	\$10 Copay \$10 Copay (eight visits)		
Medicare Covered Podiatry	SW/WC: \$20 Copay (tour visits); OW: \$15 Copay (tour visits) SW/WC: \$20 Copay; OW: \$25 Copay	\$10 Copay (eight visits) \$0 Copay		
Routine Podiatry	SW/WC: \$20 Copay; OW: \$25 Copay SW/WC: \$20 Copay (four visits); OW: \$25 Copay (four visits)	\$0 Copay \$0 Copay (10 visits)		
Cardiac and Pulmonary Rehab, and SET, Partial Hospital, Outpatient Blood		opay		
and an entry name, and all, i di nui nospiidi, outputtetti biood	PART D DRUGS	-r-/		
Formulary	Lean (Performance)	Base (Venture)		
Initial Coverage Limit. Retail: Cost sharing is for up to 31–day supply. Can get up to 100–day supply for T1 and T2 and 90–day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Prefered Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Prefered Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail Order: Tier 1: \$15, Tier 2: \$57, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
OOP Threshold	\$2,000. Once that is met, the plan pay	s the full cost for covered Part D drugs.		
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	Tier 3 Insulin: \$35 for 31-day supply and \$60 for 90-day supply at a retail or mail order pharmacy Tier 4 Insulin: \$35 for 31-day supply and \$105 for 90-day supply		

Complete Blue PPO — WPA



Complete Blue PPO Southwest

Complete Blue PPO West Central

Complete Blue PPO Northwest

^{*}Pricing is subject to CMS approval

IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages

Complete Blue PPO - WPA (Products and pricing by county)

	NEW! MERIT	NEW! CHOICE	NEW! CHOICE DELUXE
M III DI D	ļ.		
Monthly Plan Premium Part B Premium Buyback	\$0 WC/NW: \$84; SW: \$83	\$0 \$19	\$6 \$0
Out-of-Pocket Maximum	Network: \$7,950; Combined: \$8,950	Network: \$6,500; Combined: \$8,950	Network: \$6,500; Combined: \$9,550
Medical Deductible			
(+ indicates deductible applies before cost sharing)	\$175	N/A	N/A
PCP Office Visit	\$0 Copay IN; \$0 Copay OON+	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Specialist Office Visit	\$40 Copay IN; \$50 Copay OON+	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay (Lab) IN, \$0 Copay (Diagnostic) IN+; 25 Copay OON+	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay (Lab) IN, \$0 Copay (Diagnostic) IN+; 25 Copay OON+	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON
X-rays	\$20 Copay IN+; \$35 Copay OON+ (Deductible does not apply to diagnostic mammograms IN)	\$25 Copay IN; \$35 Copay OON	\$20 Copay IN; \$20 Copay OON
Radiation Therapy	\$60 Copay IN+; \$80 Copay OON+	\$75 Copay IN: \$80 Copay OON	\$75 Copay IN; \$75 Copay OON
Advanced Imaging	\$300 Copay IN+; \$325 Copay OON+	\$225 Copay IN; \$325 Copay OON	\$225 Copay IN; \$225 Copay OON
Preventive/Screening			Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	\$35 Copay IN+; \$35 Copay OON+	\$25 Copay IN; \$35 Copay OON	\$20 Copay IN; \$40 Copay OON
Medicare Covered Acupuncture	\$35 Copay IN+; \$35 Copay OON+	\$25 Copay IN; \$35 Copay OON	\$20 Copay IN; \$40 Copay OON
Outpatient Occupational Therapy	\$35 Copay IN+; \$50 Copay OON+	\$25 Copay IN; \$50 Copay OON	\$20 Copay IN; \$40 Copay OON
Outpatient Mental Health	\$40 Copay IN+; \$50 Copay OON+	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$40 Copay OON
Outpatient Substance Abuse	\$45 Copay IN+; \$50 Copay OON+	\$45 Copay IN; \$50 Copay OON	\$45 Copay IN; \$50 Copay OON
Outpatient Surgical	\$275 Copay IN+; \$375 Copay OON+ (Deductible does not apply to diagnostic colonoscopy IN)	ASC: \$200 Copay IN; \$325 Copay OON	ASC: \$200 Copay IN; \$200 Copay OON
	Facility: \$325 Copay IN+; \$375 Copay OON+	Facility: \$300 Copay IN; \$375 Copay OON	Facility: \$300 Copay IN; \$300 Copay OON
Ambulance	Emergent/Non-Emergent: \$375 IN;	Emergent/Non-Emergent: \$375 IN;	Emergent/Non-Emergent: \$400 IN;
Transportation	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON surance OON. Covered only if trip is part of continued acute care a	Non-Emergent: 30% Coinsurance OON
Transportation			
Emergency Room	\$110 Copay	\$125 Copay	\$125 Copay
Urgent Care	\$45 Copay	\$50 Copay	\$50 Copay
Inpatient Hospital Stay	\$400/day (days 1 – 5) IN, \$0/day (days 6 – 90) IN+; \$600/day (days 1 – 3), \$0/day (days 4 – 90) OON+	\$175/day (days 1 – 5) IN, \$0/day (days 6 – 90) IN; \$300/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$325/admit IN; \$325/admit OON
Inpatient Psychiatry Stay	\$400/day (days 1 – 5), \$0/day (days 4 – 90) 00N+ \$400/day (days 1 – 5), \$0/day (days 6 – 90) IN+;	\$425/day (days 1 – 3), \$0/day (days 6 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;
inpulient r sychian y stay	\$475/day (days 1 – 3), \$0/day (days 4 – 90) OON+	\$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$475/day (days1 = 3), \$0/day (days 4 = 90) OON
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN+;	\$0/day (days 1 – 20); \$214/day (days	
	30% Coinsurance OON+		
Home Health	\$0 Copay IN+; 30% Coinsurance OON+		Coinsurance OON
Diabetic Supplies and Services		order pharmacy limited to Abbott and LifeScan, all other brands are pharmacy are limited to Abbott and Dexcom, 20% coinsurance for c	
Durable Medical Equipment	20% Coinsurance IN+; 30% Coinsurance OON+	pharmacy are illilled to Abbott and Dexcom, 20% comsurance for a	20% Coinsurance IN; 30% Coinsurance OON
OTC	\$40 Allowance Once Per Quarter	Covered in Flex Card benefit	Covered in Flex Card benefit
Flex Card	Q40 Allowance Office Fer Quarter	COVERCE IN THEX CARE DETICIN	WC/NW: Dental, Vision, Hearing, OTC — \$430; Part B — \$200
	N/A	Dental, Vision, Hearing, OTC — \$445	(\$50 Transaction Limit); SW: Dental, Vision, Hearing, OTC — \$425 Part B — \$200 (\$50 Transaction Limit)
Onduo	\$0 Onduo Virtual Diabetes Program for Dia	betes. Members can see an endocrinologist and receive a glucome	
Spring Health		ital tools, coaching, in-person and virtual clinical support to help m	
CHF and COPD Management powered by Vida			
, ,	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN		
Hoalth care Vite			
Health care Kits		N/A 32 cradits per month; pe rellever of cradits	
Fitness Benefit		32 credits per month; no rollover of credits	
Fitness Benefit Additional Telehealth Services		32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient	
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C	oinsurance for all other Part B drugs IN; 30% Coinsurance OON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C	N; \$35 Copay OON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON	
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance t \$40 Copay IN; \$50 Copay OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post: \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adva	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) saced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 conced — \$699 copay; IN; \$500 copay I	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adva	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post: \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) solumance IN/OON for any other hearing aid ay: \$0 Copay IN; 30% Coinsurance OON (One every year)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Hearing (Hearing Aids)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adva	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) saced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 conced — \$699 copay; IN; \$500 copay I	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 arry six months) Includes exam, cleaning, and fluoride treatment; X-	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) solumance IN/OON for any other hearing aid ay: \$0 Copay IN; 30% Coinsurance OON (One every year)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance II \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ 2 Hearing Aids Every year; TruHearing Adva Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) naced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 copry six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sallowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximu imum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 ery six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 , Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 OON	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sallowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Hearing Aids) Routine Hearing Aids Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to 20% Coinsurance 20% Copay IN; 850 Copay OON+ \$20 Copay IN; 820 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adva Office Visit: 80 Copay IN; 80% Coinsurance OON (One ever \$40 Copay IN; 850 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$699 copay; TruHearing Premium — \$999 copay IN; \$500 copay Serviced or \$4,000 companies of \$4,000 Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximu imum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 ery six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 , Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 OON	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 COON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Routine Podiatry	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance to \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adva Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 COPAY ON+ \$15 Copay IN; \$35 COPAY ON (four visits)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin li \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON ary six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray: \$0 Copay IN; \$30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET,	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance 1 \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$0 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 OON+ \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin li \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$699 copay; Truthearing Premium — \$999 copay IN; \$500 cary six months) Includes exam, cleaning, and fluoride treatment; X— \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 OON \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a catarcact eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray: \$0 Copay IN; \$30 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON \$25 Copay IN; \$25 Copay OON (four visits)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET,	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance 1 \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Oopay OON (four visits) \$40 Copay IN; \$50 Copay OON+ \$40 Copay IN; \$50 Copay OON+ \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin li \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum mor specialty contact lenses. \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced — \$699 copay; Truthearing Premium — \$999 copay IN; \$500 cary six months) Includes exam, cleaning, and fluoride treatment; X— \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 OON \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray: \$0 Copay IN; \$30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every year) \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON+ \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$0 Copay IN; \$30 Coinsurance OON+	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum mor specialty contact lenses. \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$999 copay; Trul+earing Premium — \$999 copay IN; \$500 copay six months) Includes exam, cleaning, and fluoride treatment; X— \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), oral/Maxillofacial Surg \$15 Copay IN; \$35 OON \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (four visits)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adve Office Visit; \$0 Copay IN; 30% Coinsurance OON (One every year) \$40 Copay IN; \$35 Copay OON+ Combined maximum allowance of \$1,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$0 Copay IN; 30% Coinsurance OON+ PART D Lean (Performance)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specially contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced — \$699 copay; TruHearing Premium — \$999 copay IN; \$50 copay Sopay IN; \$50 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON \$30 Copay IN; \$35 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) allowance IN/OON for any other hearing aid ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 COPAY (Four visits) \$25 Copay IN; \$15 COPAY OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance)
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$30% Coinsurance OON (One ever year) 2 Hearing Aids Every year; TruHearing Adva Office Visit: \$0 Copay IN; \$30% Coinsurance OON (One ever \$40 Copay IN; \$30% Coinsurance OON (One ever \$40 Copay IN; \$35 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 COpay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$0 Copay IN+; 30% Coinsurance OON+ PART D Lean (Performance) Tier 1 – Tier 2: \$0, Tier 3 – Tier 5: \$550	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON. A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON copay IN; \$30 Copay OON combined maximum allowance of \$4,000 prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$15 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray: \$0 Copay IN; \$30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON+ \$15 Copay IN; \$35 Copay OON+ \$40 Copay IN; \$35 Copay OON+ \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$30 Coinsurance OON+ PART D Lean (Performance) Tier 1 - Tier 2: \$0, Tier 3 - Tier 5: \$550 Preferred Retail: Tier 1: \$0, Tier 2: \$0,	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum mor specialty contact lenses. \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced – \$699 copay; Truthearing Premium – \$999 copay IN; \$500 cary six months) Includes exam, cleaning, and fluoride treatment; X– \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 COPay OON \$15 Copay IN; \$35 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; 30% DRUGS Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0,	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$15 Copay OON \$25 Copay IN; \$25 Copay OON (four visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0,
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance 1 \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ Combined maximum allowance OON (One ever \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$50 Copay IN+; 30% Coinsurance OON+ PART D Lean (Performance) Tier 1 – Tier 2: \$0, Tier 3 – Tier 5: \$550 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 21%, Tier 4: 25%, Tier 5: 25%	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON cry six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four visits) Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 erry, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (four visits) \$26 Copay IN; \$25 Copay OON (four visits) \$27 Coinsurance OON Lean (Performance) \$20 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible nitial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance 10% Coinsurance ON+ 840 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 OON+ \$15 Copay IN; \$35 Copay OON+ \$40 Copay IN; \$50 Copay OON (four visits) \$0 Copay IN; \$50 Copay OON (four visits) \$15 Copay IN; \$50 Copay OON (four visits) \$16 Copay IN; \$50 Copay OON (four visits) \$17 Copay IN; \$50 Copay OON (four visits) \$18 Copay IN; \$50 Copay OON (four visits) \$18 Copay IN; \$50 Copay OON (four visits) \$19 Copay IN; \$50 Copay OON (four visits) \$10 Copay IN; \$50 Copay OON (four visits) \$10 Copay IN; \$50 Copay OON (four visits) \$11 Copay IN; \$50 Copay OON (four visits) \$12 Copay IN; \$50 Copay OON (four visits) \$13 Copay IN; \$50 Copay OON (four visits) \$14 Copay IN; \$50 Copay OON (four visits) \$15 Copay IN; \$50 Copay OON (four visits)	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Cup to a maximum of a \$35 copay for a one month supply of insulin li \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) anced — \$699 copay; TrutHearing Premium — \$999 copay IN; \$500 cory six months) Includes exam, cleaning, and fluoride treatment; X— \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 , Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$35 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four Fixed) Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: \$0%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15,	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 5: \$22,0,
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Comprehensive Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of 20% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advorous Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every \$40 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$1,500 \$15 Copay IN; \$35 Copay OON+ \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$0 Copay IN; \$35 Copay OON (four visits) \$15 Copay IN; \$35 Copa	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specially contact lenses. \$200 benefit maximum for post. \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) anced — \$699 copay; TruHearing Premium — \$999 copay IN; \$50 copay Son Copay IN; \$50 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay Con (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 erry, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay IN; \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Gyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of Standard Eyeglass lenses and frames or \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; 30% Coinsurance OON (One ever \$40 Copay IN; \$30% Coinsurance OON (One ever \$40 Copay IN; \$30% Coinsurance OON (One ever \$40 Copay IN; \$35 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$0 Copay IN+; 30% Coinsurance OON+ PART D Lean (Performance) Tier 1 - Tier 2: \$0, Tier 3 - Tier 5: \$550 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 21%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 21%, Tier 4: 25%, Tier 5: 25% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 5: 25% Preferred Mail: Tier 1: \$0, Tier 2: \$0,	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON. A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post- \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON compaired—\$599 copay; TruHearing Premium—\$999 copay IN; \$500 or y six months) Includes exam, cleaning, and fluoride treatment; X— \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) standard Frames and a cataract eyewear. standard Frames and a cataract eye and a catarac
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of 20% Coinsurance of 30% Coinsurance of \$40 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every year) \$40 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON+ \$15 Copay IN; \$35 Copay OON+ \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$30 Copay OON (four visits) \$0 Copay IN; \$30 Coinsurance OON+ PART D Lean (Performance) Tier 1 – Tier 2: \$0, Tier 3 – Tier 5: \$550 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 21%, Tier 4: 25%, Tier 5: 25% Preferred Mail: Tier 1: \$7, Tier 2: \$15, Tier 3: 21%, Tier 4: 25%, Tier 5: 25% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 21%, Tier 4: 25%, Tier 5: 25%	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coupy to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON Combined maximum - \$999 copay IN; \$500 cary six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (\$0 Palliative. 50% All other \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$25%, Tier 4: 50%, Tier 5: 33%
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit)	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+ 20% Coinsurance of S40 Copay IN; 550 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 Copay OON+ \$15 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$35 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$50 Copay IN; \$50 Copay OON (four visits) \$60 Copay IN; \$50 Copay OON (four visits) \$70 Copay IN; \$75 Copay OON (four visits) \$71 Copay IN; \$75 Copay IN;	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum imum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON, S30 Copay IN; \$30 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$1, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45,	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) sllowance IN/OON for any other hearing aid ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 erry, and Adjunctive General Services (\$0 Palliative. 50% All others \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 5: 33% Standard Mail: Tier 1: \$1, Tier 5: \$30, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$2, Tier 5: \$30, Tier 5: \$33% Standard Mail: Tier 1: \$2, Tier 5: \$30, Tier 5: \$33%
Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply, Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+20% Coinsurance OON+840 Copay IN; \$50 Copay OON+ Standard Eyeglass lenses and frames or \$200 benefit max \$40 Copay IN; \$50 Copay OON+ \$20 Copay IN; \$50 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advo Office Visit: \$0 Copay IN; \$50 Copay OON+ Combined maximum allowance of \$1,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics \$15 Copay IN; \$35 OON+ \$15 Copay IN; \$35 Copay OON+ \$40 Copay IN; \$50 Copay OON (four visits) \$40 Copay IN; \$50 Copay OON (four visits) \$50 Copay IN; \$50 Copay OON (f	32 credits per month; no rollover of credits Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coupy to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) contact lenses are covered in full. IN/OON: A \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON Combined maximum - \$999 copay IN; \$500 cary six months) Includes exam, cleaning, and fluoride treatment; X- \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$4,000 Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg \$15 Copay IN; \$35 Copay OON \$30 Copay IN; \$30 Copay OON (four visits)	N; \$35 Copay OON \$25 Copay IN; \$25 Copay OON m applies to non-standard frames and a cataract eyewear. \$25 Copay IN; \$25 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) solution of any other hearing aid ay: \$0 Copay IN; \$30 Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$6,000 ery, and Adjunctive General Services (50 Palliative. 50% All othe \$15 Copay IN; \$15 COpay OON (four visits) \$25 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON (four visits) Coinsurance OON Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%

Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

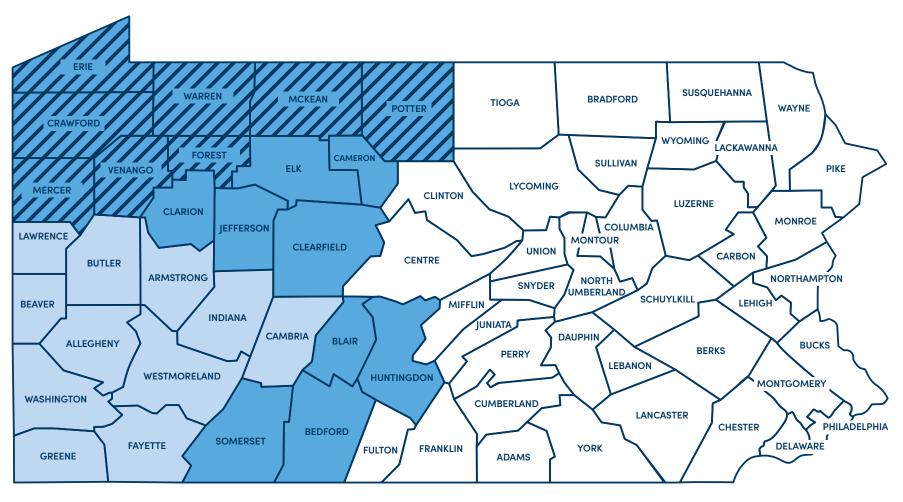
MEDICARE ADVANTAGE | PRODUCTS AND PRICING BY COUNTY

Complete Blue PPO — WPA (Products and pricing by county)

	SIGNATURE	SIGNATURE	DISTINCT	PREMIER
Monthly Plan Premium	SW/WC: \$0	NW: \$0	\$12	\$49
Part B Premium Buyback	SW: \$9 / WC: \$8	\$8	\$0	SW/NW: \$1; WC: \$0
Out-of-Pocket Maximum	Network: \$6,500; Combined: \$8,950	Network: \$6,500; Combined: \$8,950	Network: \$5,500; Combined: \$9,550	Network: \$4,500; Combined: \$8,950
PCP Office Visit	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Specialist Office Visit	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON	\$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests				
(Phys. Office or Freestanding Lab)	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN: \$0 Copay OON
X-rays	\$20 Copay IN; \$35 Copay OON	\$20 Copay IN; \$30 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON
Radiation Therapy	\$60 Copay IN; \$80 Copay OON	\$60 Copay IN; \$90 Copay OON	\$50 Copay IN; \$50 Copay OON	\$50 Copay IN; \$50 Copay OON
Advanced Imaging	\$195 Copay IN; \$325 Copay OON	\$195 Copay IN; \$300 Copay OON	\$175 Copay IN; \$175 Copay OON copay may apply) IN/OON	\$150 Copay IN; \$150 Copay OON
Preventive/Screening	*****	40.0 111.40.0 0.011		
Outpatient Physical and Speech Therapy	\$20 Copay IN; \$35 Copay OON	\$20 Copay IN; \$30 Copay OON	\$5 Copay IN; \$5 Copay OON	\$0 Copay IN; \$0 Copay OON
Medicare Covered Acupuncture	\$20 Copay IN; \$35 Copay OON	\$20 Copay IN; \$30 Copay OON	\$5 Copay IN; \$5 Copay OON	\$0 Copay IN; \$0 Copay OON
Outpatient Occupational Therapy	\$30 Copay IN; \$50 Copay OON	\$30 Copay IN; \$60 Copay OON	\$30 Copay IN; \$40 Copay OON	\$0 Copay IN; \$0 Copay OON
Outpatient Mental Health	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$60 Copay OON	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON
Outpatient Substance Abuse	\$45 Copay IN; \$50 Copay OON	\$45 Copay IN; \$60 Copay OON	\$45 Copay IN; \$50 Copay OON	\$30 Copay IN; \$30 Copay OON
Outpatient Surgical	ASC: \$195 Copay IN; \$325 Copay OON	ASC: \$175 Copay IN; \$300 Copay OON	ASC: \$175 Copay IN; \$175 Copay OON	ASC: \$125 Copay IN; \$125 Copay OON
	Facility: \$245 Copay IN; \$375 Copay OON	Facility: \$225 Copay IN; \$350 Copay OON	Facility: \$200 Copay IN; \$200 Copay OON	Facility: \$200 Copay IN; \$200 Copay OON
Ambulance	Emergent/Non-Emergent: \$260 IN;	Emergent/Non-Emergent: \$390 IN;	Emergent/Non-Emergent: \$260 IN;	Emergent/Non-Emergent: \$270 IN;
	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
Transportation			is part of continued acute care after discharge from E	
Emergency Room		\$125 0		
Urgent Care	\$50 Copay	\$50 Copay	\$30 Copay	\$15 Copay
Inpatient Hospital Stay	\$145/day (days 1 – 5) IN, \$0/day (days 6 – 90) IN;	• • • • • • • • • • • • • • • • • • • •	· ·	· ·
(COVID-19 cost share waiver has been removed)	\$300/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$250/admit IN; \$475/admit OON	\$275/admit IN; \$275/admit OON	\$225/admit IN; \$225/admit OON
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	*****
	\$475/day (days 1 – 3), \$0/day (days 4 – 90) NON	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$300/admit IN; \$300/admit OON
Skilled Nursing Facility			s 21 – 100) IN; 30% Coinsurance OON	
Home Health			Coinsurance OON	
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Diabetic Supplies and Services			and Litescan, all other brands are covered inrough a l nd Dexcom, 20% coinsurance for all other covered diak	
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отс	SW: \$165 Allowance Once Per Quarter	\$150 All O B Ot	\$105 Allowance Once Per Quarter	SW: \$185 Allowance Once Per Quarter WC: \$195 Allowance Once Per Quarter
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Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conta \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endadontic fixed), Oral/Maxillofacial Surgery, and Adjunctic 50% Coinsurance OON. S \$15 Copay IN; \$35 OON	etes Program for Diabetes. Members can see an endo re program with digital tools, caaching, in-person and D and Congestive Heart Failure to manage condition t in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 cappy f \$20 Cappy IN; \$20 Cappy OON \$0 Cappy IN; \$50 Cappy OON \$0 Cappy IN; \$50 Cappy OON \$0 Cappy IN; \$50 Cappy OON \$20 Cappy IN; \$50 Cappy OON \$20 Cappy IN; \$50 Cappy OON \$20 Cappy IN; \$20 Cappy OON \$20 Cappy IN; \$20 Cappy OON \$25 Cappy IN; \$25 Cappy OON (One every year) Ar; TruHearing Advanced \$699 cappy; TruHearing IVsit: \$0 Cappy IN; 30% Coinsurance OON (One every X-ray: \$0 Cappy IN; 30% Coinsurance ON (One every X-ray: \$0 Cappy IN; 30% Coinsurance ON (One every X-ray: \$0 Cappy IN; \$20 Cappy OON Combined maximum allowance of \$2,500 cs, Periodontics, Prosthodontics (removable and/or ve General Services (\$0 Palliative. 20% All others). ee EOC for benefit limits.	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address beh through an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurar or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON fesix months) Includes exam, cleaning, and fluoride treaurance OON (One every year) \$10 Copay IN; \$10 Copay OON (One severy year) Premium — \$999 copay IN; \$500 allowance IN/OON fesix months) Includes exam, cleaning, and fluoride treaurance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Presidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others), 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$15 OON	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON benefit maximum for specialty contact lenses. \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) or any other hearing aid timent \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON
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Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$0 behavioral health ca \$0 program for COP 0% – 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctifixed), Oral/Maxillofacial Surgery, and Adjunctifixed), S15 Copay IN; \$35 OON \$15 Copay IN; \$35 OON (four visits) \$20 Copay IN; \$35 Copay OON (four visits)	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition 1 in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay OON \$0 Copay IN; \$50 Copay OON \$20 Copay IN; \$50 Copay OON \$20 Copay IN; \$50 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) ar; TruHearing Advanced — \$699 copay; TruHearing IVisit: \$0 Copay IN; \$30 Coinsurance OON (One every X-ray: \$0 Copay IN; \$30 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$30 COpay OON \$35 Copay IN; \$30 COpay OON (Four visits) \$20 Copay IN; \$30 Copay OON (four visits) \$20 Copay IN; \$30 Copay OON (four visits)	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address beh through an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurator a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for six months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON (One oon this months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON (One Premium — \$999 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON (One Premium — \$10 Copay IN; \$10 Copay OON	avioral health needs. IN ans, health coaches, SO Copay IN; SO Copay OON benefit maximum for specialty contact lenses. SO Copay IN; SO Copay OON SO Copay IN; SO Copay OON (One every year) or any other hearing aid ttment SO Copay IN; SO Copay OON Combined maximum allowance of \$3,500 SO Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON (eight visits)
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Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 behavioral health co \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON 2 Hearing Aids Every year) 2 Hearing Aids Every year) Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctif 50% Coinsurance OON. S \$15 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$35 Copay OON (four visits)	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) ar; TruHearing Advanced — \$699 copay; TruHearing IVisit: \$0 Copay IN; 30% Coinsurance OON (One every X-ray: \$0 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$35 Copay IN; \$30 Copay OON \$35 Copay IN; \$30 OON \$35 Copay IN; \$30 OON \$35 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (four visits)	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address beh through an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurator a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON OON (One every year) (ON) (One every year) (ON) (One every year) (ON) (One every year) (ON) (ON) (ON) (ON) (ON) (ON) (ON) (ON	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$30 Copay IN; \$30 Copay OON \$40 Copay IN; \$40 Copay OON \$50 Copay IN; \$50 Copay OON
Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Alds) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctifixed), Oral/Maxillofacial Surgery, and Adjunctifixed, Oral/Maxillofacial Surgery, and Adjunctifixed, Oral/Maxillofacial Surgery, and Oral/Maxillofacial Surgery, and Oral/Maxillofacial Surgery, and Oral/Maxillofacial Surg	stes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition i in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay OON \$0 Copay IN; \$50 Copay OON \$0 Copay IN; \$50 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) \$27 Turlbearing Advanced — \$699 copay; Trulbearing IV Visit: \$0 Copay IN; 30% Coinsurance OON (One every X-ray: \$0 Copay IN; 30% Coins \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 \$25 Copay IN; \$30 Copay OON \$25 Copay IN; \$30 Copay OON \$26 Copay IN; \$30 Copay OON \$27 Combined maximum allowance of \$2,500 \$30 Copay IN; \$30 Copay OON \$315 Copay IN; \$30 Copay OON \$315 Copay IN; \$30 Copay OON \$320 Copay IN; \$30 Copay OON (four visits) \$30 Copay IN; \$30 Copay OON (four Visits)	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address bed hirrough an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurator a one month supply of insulin IN; 335 Copay ON \$10 Copay (N); \$10 Copay OON \$10 Copay (N); \$10 Copay OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON fesix months) Includes exam, cleaning, and fluoride treaurance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Presidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others). 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$15 Copay OON (four visits)	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON benefit maximum for specialty contact lenses. \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) or any other hearing aid trment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. 50% Coinsurance OON. \$ee EOC for benefit limits. \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$30 Copay OON (10 visits)
Onduo Spring Health Spring Health CNF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctif 50% Coinsurance OON. \$ \$15 Copay IN; \$35 COpay OON (four visits) \$20 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (four visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0,	stes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition 1 in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay ct lenses are covered in full. IN/OON: A \$200 benefit n \$200 benefit maximum fe \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 \$20 Copay IN; \$20 Copay OON \$30 Copay IN; \$20 Copay OON \$40 Combined maximum allowance of \$2,500 \$41 Combined maximum allowance of \$2,500 \$42 Copay IN; \$20 Copay OON \$43 Copay IN; \$20 Copay OON \$45 Copay IN; \$20 Copay OON \$50 Copay IN; \$20 Copay OON	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address beh through an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurator or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON OON (One every year) noustimum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$10 Copay OON S10 Copay IN; \$10 Copay OON (One overy year) Premium — \$999 copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One every year) S10 Copay IN; \$10 Copay OON (One year) S10 Copay IN; \$10 Copay OON (One year) S10 Copay IN; \$10 Copa	avioral health needs. IN ans, health coaches, SO Copay IN; SO Copay OON benefit maximum for specialty contact lenses. SO Copay IN; SO Copay OON SO Copay IN; SO Copay OON One every year) or any other hearing aid attment SO Copay IN; SO Copay OON Combined maximum allowance of \$3,500 SO Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, So's Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON (eight visits) SO Copay IN; \$20 Copay OON (eight visits) SO Copay IN; SO Copay OON (10 visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0,
Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctif 50% Coinsurance OON. \$ \$15 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (four visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebotable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 capay f \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 \$25 Copay	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address beh frough an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurar or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON [S10 Copay IN; \$10 Copay OON] y OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON fest months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Presidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others), 50% Coinsurance OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Co	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON benefit maximum for specialty contact lenses. \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, 50% Coinsurance OON. \$20 Copay IN; \$20 Copay OON (eight visits) \$20 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON (solvisits) \$0 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON (eight visits) \$20 Copay IN; \$20 Copay OON (folvisits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
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Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2, and 90-day supply for T3 and T4 at 3x copay, except Specialty Fier 5.	\$0 behavioral health co \$0 program for COP 0% – 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$20 Copay OON 2 Hearing Aids Every year) 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctifixed), Oral/Maxi	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay OON \$0 Copay IN; \$50 Copay OON \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) ar; TruHearing Advanced — \$699 copay; TruHearing IVisit: \$0 Copay IN; 30% Coinsurance OON (One every X-ray: \$0 Copay IN; 30% Coinsurance OON (One every X-ray: \$0 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$35 Copay IN; \$30 Copay OON \$40 Combined maximum allowance of \$2,500 \$40 Copay IN; \$30 Copay OON \$50 Copay IN; \$30 Copay OON \$50 Copay IN; \$30 Copay OON; \$50 Copay IN; \$30 C	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address bed hrough an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurator a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON fesix months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others), 50% Coinsurance OON. See EcO for benefit limits. \$15 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$10 Copay OON (four visits) Coinsurance OON	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable-fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, 50% Coinsurance OON. \$20 Copay IN; \$20 Copay OON (eight visits) \$20 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay I
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Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2, and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2, and up to a 90-day supply for T1 and T4, and up to a 90-day supply for T3 and T4, except Specialty tier	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctic 50% Coinsurance OON. \$ \$15 Copay IN; \$35 OON \$15 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$21 Copay IN; \$22 Copay OON (four visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebotable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 capay f \$20 Capay IN; \$20 Capay ON \$20 Capay IN; \$2	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address bed hirrough an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurar or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium - \$999 copay IN; \$500 allowance IN/OON fest months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Presidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others). 50% Coinsurance OON \$15 Copay IN; \$15 Copay OON (four visits) \$15 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay IN	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON benefit maximum for specialty contact lenses. \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) or any other hearing aid timent \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, 50% Coinsurance OON, See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$20 Copay OON (eight visits) \$0 Copay IN; \$30 Copay OON (to visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$50, Tier 3: 25%, Tier f: 1: \$21, Tier 2: \$50, Tier 3: 25%, Tier f: 1: \$21, Tier 2: \$50, Tier 3: 25%, Tier f: 1: \$21, Tier 2: \$33%
Onduo Spring Health CNF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Podiatry Routine Podiatry Routine Podiatry Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2, and 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a 90-day supply for T1 and T2, and up to a	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctif 50% Coinsurance OON. S \$15 Copay IN; \$35 COpay OON (four visits) \$20 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (four visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay Ct lenses are covered in full. IN/OON: A \$200 benefit n \$200 benefit maximum fe \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 \$20 Copay IN; \$20 Copay OON \$20 Copay	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address bet hrough an app. Members will receive help from dietiting, and regular mental health assessments. IN in or rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurar or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON OON (One every year) noustimum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for six months) Includes exam, cleaning, and fluoride free currance OON (One every year) \$10 Copay IN; \$10 Copay OON (One overy year) \$10 Copay IN; \$10 Copay OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (So Palliative. 10% All others), 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$15 Copay OON (four visits) \$10 Copay IN; \$10 Copay OON	avioral health needs. IN ans, health coaches, SO Copay IN; SO Copay OON benefit maximum for specialty contact lenses. SO Copay IN; SO Copay OON SO Copay IN; SO Copay OON SO Copay IN; SO Copay OON Combined maximum allowance of \$3,500 SO Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, So's Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON (eight visits) SO Copay IN; \$20 Copay OON (eight visits) SO Copay IN; SO Copay OON (10 visits) Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$7, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2, and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2, and up to a 90-day supply for T1 and T4, except Specialty tier 5.	\$0 behavioral health ca \$0 program for COP 0% - 19.9 \$20 Copay IN; \$20 Copay OON Standard Eyeglass lenses and frames or conto \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$25 Copay IN; \$25 Copay OON (One every year) 2 Hearing Aids Every ye Office \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 20% Coinsurance: Restorative Services, Endodontic fixed), Oral/Maxillofacial Surgery, and Adjunctic 50% Coinsurance OON. \$ \$15 Copay IN; \$35 OON \$15 Copay IN; \$35 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$20 Copay IN; \$20 Copay OON (four visits) \$21 Copay IN; \$22 Copay OON (four visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	etes Program for Diabetes. Members can see an endo re program with digital tools, coaching, in-person and D and Congestive Heart Failure to manage condition in-app trackers, lessons on symptom monitori 32 credits per month; Services covered with applica 9% Coinsurance for Part B rebatable drugs and 20% C 20% Coinsurance up to a maximum of a \$35 copay f \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$50 Copay Ct lenses are covered in full. IN/OON: A \$200 benefit n \$200 benefit maximum fe \$20 Copay IN; \$20 Copay OON Combined maximum allowance of \$2,500 \$20 Copay IN; \$20 Copay OON \$20 Copay	crinologist and receive a glucometer with an unlimited virtual clinical support to help members address bed hirrough an app. Members will receive help from dietiting, and regular mental health assessments. IN no rollover of credits ble Copay listed for outpatient oinsurance for all other Part B drugs IN; 30% Coinsurar or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (One every year) naximum applies to non-standard frames and a \$200 or post cataract eyewear. \$10 Copay IN; \$10 Copay OON (One every year) Premium - \$999 copay IN; \$500 allowance IN/OON fest months) Includes exam, cleaning, and fluoride treaturance OON (One every year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 10% Coinsurance: Restorative Services, Endodontics, Presidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 10% All others). 50% Coinsurance OON \$15 Copay IN; \$15 Copay OON (four visits) \$15 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay IN	avioral health needs. IN ans, health coaches, \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON benefit maximum for specialty contact lenses. \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) or any other hearing aid timent \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3,500 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services, 50% Coinsurance OON, See EOC for benefit limits. \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$30 Copay OON (ion visits) \$0 Copay IN; \$30 Copay OON (ion visits) Lean (Performance) Preferred Retail: Tier 1: 50, Tier 5: 33% Standard Retail: Tier 1: 50, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$3, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$3, Tier 2: \$0, Tier 3: 25%, Tier 1: \$21, Tier 5: 33% Standard Mail: Tier 1: \$3, Tier 2: \$0, Tier 3: 25%, Tier 1: \$21, Tier 1: 250, Tier 3: 25%, Tier 1: \$21, Tier 1: 250,

Confidential and Proprietary — For Agent Use Only

Security Blue HMO-POS — WPA





Security Blue HMO-POS Southwest



Security Blue HMO-POS West Central



Security Blue HMO-POS Other West Central

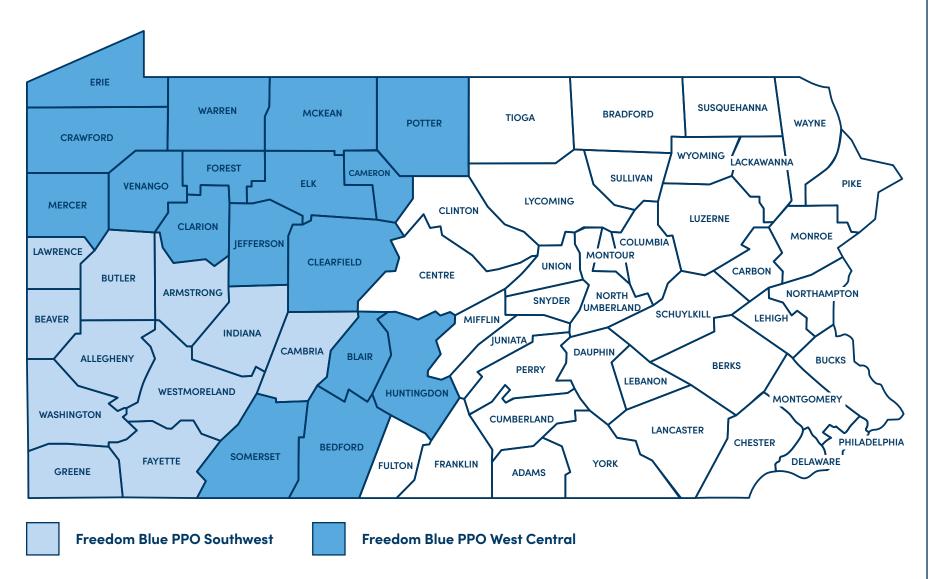
^{*}Pricing is subject to CMS approval

Security Blue HMO-POS — WPA (Products and pricing by county)

	DAGIO	VALUED	OTANDA DD	DELLIVE	
	BASIC	VALUERx	STANDARD	DELUXE	
Monthly Plan Premium	SW: \$48; WC: \$47	SW: \$30; WC/OW: \$17	SW: \$140; WC: \$119	SW: \$200; WC: \$178	
Out-of-Pocket Maximum	Network: \$5,900; Combined: \$8,950	Network: \$5,500; Combined: \$8,950	Network: \$5,000; Combined: \$8,950	Network: \$4,500; Combined: \$8,950	
PCP Office Visit	\$0 Copay IN; \$0 Copay POS	\$0 Copay IN; \$0 Copay POS	\$0 Copay IN; \$0 Copay POS	\$0 Copay IN; \$0 Copay POS	
Specialist Office Visit	\$30 Copay IN; \$30 Copay POS	\$35 Copay IN; \$40 Copay POS	\$30 Copay IN; \$30 Copay POS	\$25 Copay IN; \$25 Copay POS	
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$30 Copay POS	ay POS \$0 Copay IN; \$25 Copay POS \$0 Copay IN; \$15 Copay POS		\$0 Copay IN; \$15 Copay POS	
Lab and Diagnostic Tests (Outpatient Facility)	\$20 Copay IN; \$30 Copay POS	\$20 Copay IN; \$30 Copay POS \$20 Copay IN; \$25 Copay POS \$10 Copay IN; \$15 Copay IN		\$10 Copay IN; \$15 Copay POS	
X-rays	\$25 Copay IN; \$40 Copay POS	\$20 Copay IN; \$25 Copay POS	\$20 Copay IN; \$35 Copay POS	\$15 Copay IN; \$30 Copay POS	
Radiation Therapy	S60 Copay IN; \$75 Copay POS			, , , , , , , , , , , , , , , , , , , ,	
Advanced Imaging	\$100 Copay IN; \$175 Copay POS	\$175 Copay IN; \$225 Copay POS	\$125 Copay IN; \$175 Copay POS	\$75 Copay IN; \$125 Copay POS	
Preventive/Screening			copay may apply) IN/POS	, , , , , , , , , , , , , , , , , , , ,	
Outpatient Physical, Speech and Occupational	\$20 Canay IN: \$45 Canay BOS		\$30 Copay IN; \$35 Copay POS	Occupational Therapy: \$20 Copay IN; \$30 Copay	
Therapy, Mental Health, and Substance Abuse	\$30 Copay IN; \$45 Copay POS	\$40 Copay IN; \$45 Copay POS		POS; Others: \$25 Copay IN; \$30 Copay POS	
Medicare Covered Acupuncture	\$30 Copay IN; \$45 Copay POS	\$40 Copay IN; \$45 Copay POS	\$30 Copay IN; \$35 Copay POS	\$25 Copay IN; \$30 Copay POS	
Outpatient Surgical	ASC: \$100 Copay IN; \$250 Copay POS	ASC: \$175 Copay IN; \$225 Copay POS	ASC: \$125 Copay IN; \$175 Copay POS	ASC: \$75 Copay IN; \$125 Copay POS	
	Facility: \$200 Copay IN; \$250 Copay POS	Facility: \$200 Copay IN; \$250 Copay POS	Facility: \$175 Copay IN; \$225 Copay POS	Facility: \$150 Copay IN; \$200 Copay POS	
Ambulance	\$125 Copay IN	\$245 Copay IN	\$200 Copay IN	\$150 Copay IN	
Transportation	\$0	Copay IN. Up to 24 One-way trips. Trip limit waived if tri		m ER.	
Emergency Room	AFA C	\$125 C			
Urgent Care Inpatient Hospital Stay	\$50 Copay	\$220/day (days 1 – 5), \$0/day (days 6 – 90) IN;	\$5 Copay	T.	
· · · · ·	\$340/admit IN; \$390/admit POS	\$270/day (days 1 – 5), \$0/day (days 6 – 90) POS	\$335/admit IN; \$385/admit POS	\$210/admit IN; \$260/admit POS	
Inpatient Psychiatry Stay	\$340/admit IN; \$390/admit POS	\$220/day (days 1 – 5), \$0/day (days 6 – 90) IN; \$270/day (days 1 – 5), \$0/day (days 6 – 90) POS	\$335/admit IN; \$385/admit POS	\$210/admit IN; \$260/admit POS	
Skilled Nursing Facility		\$0/day (days 1 – 20); \$21			
Home Health		\$0 Cop			
Diabetic Supplies and Services		ved via retail or mail order pharmacy limited to Abbott			
Durable Medical Equipment		lispensed via retail or mail order pharmacy are limited	to Abbott and Dexcom, 20% coinsurance for all other lealing at Home (SW Only): \$0 cost-share for DME up		
Durable Medical Equipment	20% Coinsurance IN		year upon Discharge from Inpatient Acute Hospital c		
Non-Skilled Care			ome: \$0 cost-share for 50 hours of non-skilled in hon		
non samed sure	N/A	per calendar	year upon Discharge from Inpatient Acute Hospital o	or SNF. IN Only	
отс		N/		•	
Flex Card		N/	/A		
Meal Benefit	28 Meals/14 E	Days IN upon discharge from an inpatient hospital stay,	inpatient hospital psychiatric stay, or SNF stay to the	home to qualify	
Onduo		etes Program for Diabetes. Members can see an endo			
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs. IN				
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN				
Health care Kits		and regular mental he			
Fitness Benefit Additional Telehealth Services		32 credits per month; Services covered with applical			
Part B Drugs — Chemotherapy and All Other Part B	0% 10	99% Coinsurance for Part B rebatable drugs and 20% C		anco POS	
Part B Drugs — Insulin	0%-13.	20% Coinsurance up to a maximum of a \$35 copay f		unce r O3	
Medicare Covered Vision (Office Visit)	\$30 Copay IN; \$30 POS	\$35 Copay IN; \$40 POS	\$30 Copay IN; \$30 POS	\$25 Copay IN; \$25 POS	
Routine Vision (Office Visit)	φου ευραγ πι, φου τ συ	\$0 Copay IN (O		V23 COPAY IIV, V23 1 CO	
Routine Vision (Eyewear)	Standard Evealass lenses and frames o	r contact lenses are covered in full. A \$225 benefit maxi	mum applies to non-standard frames or a \$225 bene	efit maximum for specialty contact lenses.	
		\$200 benefit maximum for po	ost cataract eyewear. IN Only	,	
Medicare Covered Hearing Exam	\$30 Copay IN; \$30 POS	\$35 Copay IN; \$40 POS	\$30 Copay IN; \$30 POS	\$25 Copay IN; \$25 POS	
Routine Hearing Exam		\$0 Copay IN (O	One every year)		
Routine Hearing (Hearing Aids)	Two Hoaring Aids overvy	rear IN; TruHearing Advanced — \$599 copay; TruHearin	ng Promium \$899 congy	Two Hearing Aids every year IN; TruHearing Advanced — \$399 copay;	
	Two freating Alds every y	ca,aaring Advanced — 9000 copuy, irunedin		TruHearing Premium — \$699 copay	
Routine Dental		Office Visit: \$15 Copay IN (One every six mo	onths) X-ray: \$15 Copay IN (One every year)	,	
Medicare Covered Comprehensive Dental	\$30 Copay IN	\$35 Copay IN	\$30 Copay IN	\$25 Copay IN	
Comprehensive Dental — Supplemental		\$0 Copay: Adjunctive Gene	eral Services (Palliative) IN		
Medicare Covered Chiropractic	\$15 Copay IN; \$30 Copay POS	\$15 Copay IN; \$40 Copay POS	\$15 Copay IN; \$30 Copay POS	\$15 Copay IN; \$25 Copay POS	
Routine Chiropractic	\$15 Copay IN (six visits)	\$15 Copay IN (six visits)	\$15 Copay IN (eight visits)	\$15 Copay IN (10 visits)	
Medicare Covered Podiatry	\$30 Copay IN; \$30 Copay POS	\$35 Copay IN; \$40 Copay POS	\$30 Copay IN; \$30 Copay POS	\$25 Copay IN; \$25 Copay POS	
Routine Podiatry	\$30 Copay IN (eight visits)	\$35 Copay IN (eight visits)	\$30 Copay IN (10 visits)	\$25 Copay IN (12 visits)	
Cardiac and Pulmonary Rehab and SET,		\$0 Copay IN; 30%	Coinsurance POS		
Partial Hospital, Outpatient Blood					
		PART D DRUGS			
Formulary	N/A	Lean (Performance)	Base (Venture)	Base (Venture)	
Initial Coverage Limit. Retail: Cost sharing is for up	N/A	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19,	Preferred Retail: N/A Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44, Tier 4: \$100, Tier 5: 33%	Preferred Retail: N/A Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	
to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.		Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Her 3. \$44, Her 4. \$100, Her 5. 55%		
T1 and T2 and 90-day supply for T3 and T4 at 3x	N/A		Standard Mail: Tier 1: \$0, Tier 2: \$32.50, Tier 3: \$110, Tier 4: \$250, Tier 5: 33%	Standard Mail: Tier 1: \$0, Tier 2: \$32.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33%	
T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) OOP Threshold		Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Prefered Mail Order: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$15, Tier 2: \$57, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33%	Standard Mail: Tier 1: \$0, Tier 2: \$32.50,	Standard Mail: Tier 1: \$0, Tier 2: \$32.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33%	
T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	N/A	Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Prefered Mail Order: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$15, Tier 2: \$57, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33% \$2,000. Onc	Standard Mail: Tier 1: \$0, Tier 2: \$32.50, Tier 3: \$110, Tier 4: \$250, Tier 5: 33%	Standard Mail: Tier 1: \$0, Tier 2: \$32.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% art D drugs.	

For Agent Use Only

Freedom Blue PPO — WPA



Freedom Blue PPO — WPA (Products and pricing by county)

	VALUERx	SELECT	CLASSIC	
M. III. D. D. I	<u> </u>			
Monthly Plan Premium Part B Premium Buyback	SW: \$45; WC: \$42 \$0	SW: \$139; WC: \$96 \$0	SW: \$252; WC: \$224 \$0	
Out-of-Pocket Maximum	Network: \$5,500; Combined: \$8,950	Network: \$5,000; Combined: \$8,950	Network: \$4,500; Combined: \$8,950	
PCP Office Visit	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	
Specialist Office Visit	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON	
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$15 Copay OON	\$0 Copay IN; \$10 Copay OON	
Lab and Diagnostic Tests (Outpatient Facility)	\$20 Copay IN; \$20 Copay OON	\$15 Copay IN; \$15 Copay OON	\$10 Copay IN; \$10 Copay OON	
X-rays	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$15 Copay IN; \$15 Copay OON	
Radiation Therapy		\$60 Copay IN; \$60 Copay OON		
Advanced Imaging	\$200 Copay IN; \$200 Copay OON	\$125 Copay IN; \$125 Copay OON	\$100 Copay IN; \$100 Copay OON	
Preventive/Screening		Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical, Speech and Occupational Therapy,	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON	
Mental Health, and Substance Abuse		1 7 7 7		
Medicare Covered Acupuncture	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON	
Outpatient Surgical	ASC: \$175 Copay IN; \$175 Copay OON	ASC: \$125 Copay IN; \$125 Copay OON	ASC: \$75 Copay IN; \$75 Copay OON	
A 1 1	Facility: \$200 Copay IN; \$200 Copay OON	Facility: \$175 Copay IN; \$175 Copay OON	Facility: \$150 Copay IN; \$150 Copay OON	
Ambulance	Emergent/Non-Emergent: \$260 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$215 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: SW \$115 IN, WC \$165 IN; Non-Emergent: 30% Coinsurance OON	
Transportation		Non-Emergent: 30% Coinsurance OON 1. Up to 24 One-way trips. Trip limit waived if trip is part of continued		
Emergency Room	\$0 Copay IN; 30% Coinsurance OON	v. up to 24 One-way trips. Trip limit waived it trip is part of confinded \$125 Copay	a deute care after discharge from ER.	
Urgent Care		\$125 Copay \$5 Copay		
Inpatient Hospital Stay	\$220/day (days 1 – 5), \$0/day (days 6 – 90) IN;			
(COVID-19 cost share waiver has been removed)	\$220/day (days 1 – 5), \$0/day (days 6 – 90) NN \$220/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$350/admit IN; \$350/admit OON	\$210/admit IN; \$210/admit OON	
Inpatient Psychiatry Stay	\$220/day (days 1 – 5), \$0/day (days 6 – 90) IN;	\$350/admit IN; \$350/admit OON	6210 / d table 6010 / - 1 - 1 0 0 N	
F	\$220/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$350/admif IN; \$350/admif OON	\$210/admit IN; \$210/admit OON	
Skilled Nursing Facility	\$	0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance O	ON	
Home Health		\$0 Copay IN; 30% Coinsurance OON		
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or ma	il order pharmacy limited to Abbott and LifeScan, all other brands	covered through a DME Supplier; continuous glucose monitors,	
		pharmacy are limited to Abbott and Dexcom, 20% coinsurance for		
Onduo		abetes. Members can see an endocrinologist and receive a glucom		
Spring Health		gital tools, coaching, in-person and virtual clinical support to help m		
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Fail	lure to manage condition through an app. Members will receive hel	p trom dietitians, health coaches, in-app trackers,	
OTC	less	sons on symptom monitoring, and regular mental health assessmen N/A	IS. IIV	
Durable Medical Equipment			at Home: \$0 cost-share for DME up to a \$1,000 allowance	
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON		charge from Inpatient Acute Hospital IN/OON	
	WC: 20% Coinsurance IN; 30% Coinsurance OON			
отс	N/A			
Flex Card	N/A			
Non-Skilled Care	N/A SW: Healing at Home: \$0 cost-share for 28 hours of non-skilled in home care related services once per calendar			
		year within 90 Days of Discharge from I	npatient Acute Hospital IN/OON; WC: N/A	
Meal Benefit	28 Meals/14 Days IN/OON upon disch	harge from an inpatient hospital stay, inpatient hospital psychiatric	stay, or SNF stay to the home to qualify	
Health care Kits		N/A		
Fitness Benefit		32 credits per month; no rollover of credits		
Additional Telehealth Services Part B Drugs — Chemotherapy and All Other Part B	0% 10 00% C-i	Services covered with applicable Copay listed for outpatient	IN 20% C-i	
Part B Drugs — Cnemornerapy and All Other Part B		Part B rebatable drugs and 20% Coinsurance for all other Part B dr up to a maximum of a \$35 copay for a one month supply of insulin I		
Medicare Covered Vision (Office Visit)	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON	
Routine Vision (Office Visit)	340 Copay III, 340 Copay OON	\$0 Copay IN; \$50 Copay OON (One every year)	aza copay III, aza copay OON	
Routine Vision (Office Visit) Routine Vision (Eyewear)	Standard Evenines lenses and frames or contact lenses are sover			
Rounne vision (Lyeweur)	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$225 benefit maximum applies to non-standard frames and a \$225 benefit maximum for specialty contact l			
	,		d frames and a \$225 benefit maximum for specialty contact lenses	
Medicare Covered Hearing Exam	, · ·	\$200 benefit maximum for post cataract eyewear.	<u> </u>	
Medicare Covered Hearing Exam Routine Hearing Exam	\$40 Copay IN; \$40 Copay OON	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON	
Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid	
Routine Hearing Exam	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 binsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year)	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 binsurance OON (One every six months) X-ray: \$15 Copay IN; 30% C \$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 cinsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid oinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv. Office Visit: \$15 Copay IN; 30% Co	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 binsurance OON (One every six months) X-ray: \$15 Copay IN; 30% C \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid oinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 oinsurance OON (One every six months) X-ray: \$15 Copay IN; 30% CO \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Pallicitive) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits)	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits)	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adve Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 sinsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; 330 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 oinsurance OON (One every six months) X-ray: \$15 Copay IN; 30% CO \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Pallicitive) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits)	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits)	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET,	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adve Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 sinsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; 330 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits)	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 insurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET,	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adve Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 sinsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; 300 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits)	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 insurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON	
Routine Hearing (Hearing Aids) Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial CoverageLimit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits) PART D Lean (Performance)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 sinsurance OON (One every six months) X-ray; \$15 Copay IN; 30% C \$30 Copay IN; 300 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits) \$25 Copay IN; \$25 Copay OON (12 visits)	
Routine Hearing (Hearing Aids) Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial CoverageLimit. Retail: Cost sharing is for up to 31-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and 17 and 18 apply for T3 and T4 except Specialty tier 5.	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$16 Copay IN; \$16 Copay OON \$40 Copay IN; \$40 Copay OON \$40 Copay IN; \$40 Copay OON S40 Copay IN; \$40 Copay OON S40 Copay IN; \$40 Copay OON (eight visits) PART D Lean (Performance)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay, IN; \$30 Copay OON (One every year) anced – \$599 copay; TruHearing Premium – \$899 copay IN; \$500 oinsurance OON (One every six months) X-ray: \$15 Copay IN; 30% CO \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay IN; \$3	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits) \$25 Copay IN; \$25 Copay OON (12 visits) Base (Venture) 3% 3%	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial CoverageLimit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 33 copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) for T3 and T4, except Specialty tier (up to 31-days supply) for T3 and T4, except Specialty tier (up to 31-days supply) for T3 and T4, except Specialty tier (up to 31-days supply) for T3 and T4, except Specialty tier	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$16 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits) PART D Lean (Performance)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 cinsurance OON (One every six months) X-ray: \$15 Copay IN; \$500 \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; \$30 Copay	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits) Base (Venture) 3% 3% 5: 33% 5: 33%	
Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial CoverageLimit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) OOP Threshold	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$16 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits) PART D Lean (Performance)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 oinsurance OON (One every six months) X-ray: \$15 Copay IN; \$500 oinsurance OON (One every six months) X-ray: \$15 Copay IN; 30% CO \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON DRUGS Base (Venture) Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 3 tandard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$47, Tier 4: \$100, Tier 5: \$1 tandard Retail: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115, Tier 4: \$275, Tier 4 dard Mail Order: Tier 1: \$15, Tier 2: \$57, Tier 3: \$141, Tier 4: \$300, Tier 100. Once that is met, the plan pays the full cost for covered Part D co	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits) Base (Venture) 3% 3% 5: 33% 5: 33% 1rugs.	
Routine Hearing Exam Routine Hearing Hearing Aids) Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Routine Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial CoverageLimit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier 5.	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Adv Office Visit: \$15 Copay IN; 30% Co \$40 Copay IN; \$40 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$16 Copay OON \$40 Copay IN; \$40 Copay OON (eight visits) PART D Lean (Performance)	\$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year) anced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 cinsurance OON (One every six months) X-ray: \$15 Copay IN; \$500 \$30 Copay IN; \$30 Copay OON \$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON \$15 Copay IN; \$15 Copay OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; \$30 Copay OON (10 visits) \$0 Copay IN; \$30 Copay	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$25 Copay OON (One every year) allowance IN/OON for any other hearing aid binsurance OON (One every year) \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON \$15 Copay IN; \$15 Copay OON (10 visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (12 visits) Base (Venture) 3% 3% 5: 33% 5: 33% 1rugs.	

WPA Growth Product Highlights

Together Blue Medicare HMO Signature

Allegheny, Butler, Erie, Washington, Westmoreland counties Strongest medical benefits across the market with coordinated care centered around AHN hospitals and doctors.

- \$37 monthly Part B giveback
- \$0 PCP, specialist, and labs, X-rays, and PT
- \$3,000 dental allowance with no coinsurance
- \$650 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- \$0 Tier 1 and 2 drugs

Community Blue Medicare HMO Signature

All WPA counties

\$0 plan with an HMO network of AHN and other high-quality local providers and richer medical benefits with predictable copays.

- \$0 PCP and Lab
- Per stay inpatient hospital
- \$3,000 dental allowance with no coinsurance
- \$0 Tier 1 and 2 drugs

NEW PLAN

Complete Blue PPO Merit

All WPA counties

\$0 plan with high monthly Part B Giveback for the most cost-conscious consumer or low utilizers that still want access to high quality care.

- \$83 or \$84 monthly Part B giveback
- \$0 PCP IN
- \$0 Tier 1 and 2 drugs with no deductible
- \$1,500 dental allowance

NEW PLAN

Complete Blue PPO Choice

All WPA counties

\$0 plan with generous core medical benefits and a flex card to give members options for how they spend their healthcare dollars.

- \$0 PCP IN and OON
- \$0 labs IN
- \$445 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- \$4,000 dental allowance

All PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals

Complete Blue PPO Signature

All WPA counties

NEW PLAN

Complete Blue PPO Choice Deluxe

All WPA counties

Complete Blue PPO Distinct

All WPA counties

Complete Blue PPO Premier

All WPA counties

Fundamental \$0 plan that provides robust and stable benefits with in-network access to AHN, UPMC and all local hospitals in WPA.

- Same cost sharing for PCP or specialist, in- or out-of-network
- \$2,500 dental allowance with low coinsurance IN
- \$0 Tier 1 and 2 drugs

Low-priced plan with strong core medical benefits and a flex card that allow members to determine how to spend their healthcare dollars.

- \$0 PCP and labs IN and OON
- Per stay inpatient hospital
- \$425 or \$430 Flex Card for use with Dental, Vision, or Hearing costs and/or OTC items
- Additional \$200 Flex allowance for most Part B outpatient copays
- \$6,000 dental allowance

Low-priced plan for members who prefer lower and more predictable out-of-pocket costs and enhanced supplemental allowances.

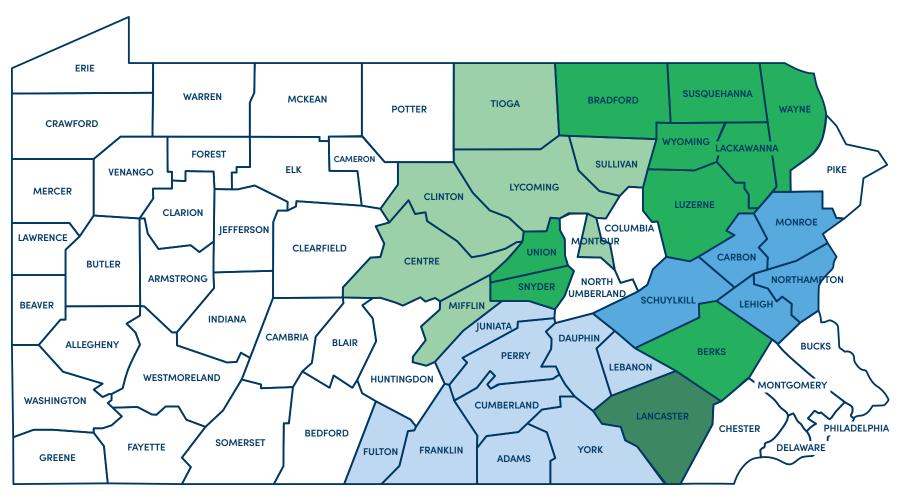
- \$0 PCP and lab; \$10 specialist; \$5 PT IN and OON
- Per stay inpatient hospital
- \$3,000 dental allowance with low coinsurance IN

Mid-priced plan offers most generous medical and supplemental benefits, with the lowest out-of-pocket costs. Great for Medigap switchers and consumers looking for peace of mind at an affordable premium.

- Low OOP Max
- \$0 PCP, specialist, lab, PT, OT IN or OON
- Same IN or OON cost-sharing for most medical benefits
- \$15 urgent care
- \$3,500 dental allowance and no coinsurance IN

For Agent Use Only

Community Blue Medicare HMO — CPA/NEPA



Community Blue Medicare HMO Harrisburg



Community Blue Medicare HMO Northeast

Community Blue Medicare HMO Lehigh Valley



Community Blue Medicare HMO North Central



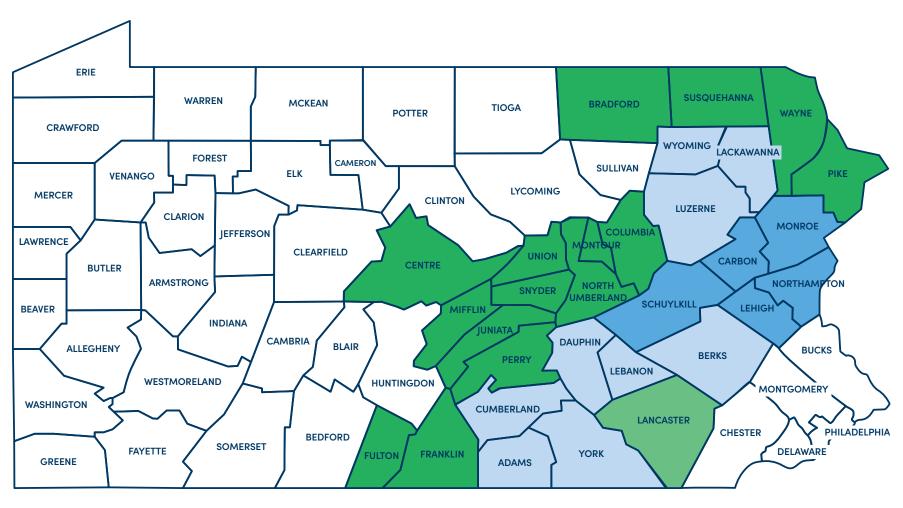
Community Blue Medicare HMO Lancaster

Community Blue Medicare HMO - CPA/NEPA (Products and pricing by county)

	SIGNATURE	SIGNATURE		
Monthly Plan Premium	Harrisburg/Northeast/Lancaster/North Central: \$0	Lehigh Valley: \$0		
Part B Premium Buyback	Harrisburg/Northeast: \$4; Lancaster/North Central: \$5 \$33			
Out-of-Pocket Maximum	Network: \$6,500; Combined: N/A			
PCP Office Visit	\$0 Copay			
Specialist Office Visit	\$0 Copay			
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay			
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay			
X-rays	\$10 Cop			
Radiation Therapy	\$60 Co			
Advanced Imaging	\$200 Co			
Preventive/Screening	Covered in Full (Office vi			
Outpatient Physical and Speech Therapy	\$20 Copay	\$0 Copay		
Medicare Covered Acupuncture	\$20 Copay	\$0 Copay		
Outpatient Occupational Therapy	\$20 Copay	\$10 Copay		
Outpatient Mental Health	\$30 Co	pay		
Outpatient Substance Abuse	\$45 Co	pay		
Outpatient Surgical	ASC: \$125 Copay; Facility: \$175 Copay	ASC: \$175 Copay; Facility: \$325 Copay		
Ambulance	\$250 Copay	\$275 Copay		
Transportation	\$0 Copay. Covered only if trip is part of contin			
Emergency Room	\$125 Co			
Urgent Care	\$0 Cop			
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$250/admit	\$295/admit		
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90)	\$425/day (days 1 – 3), \$0/day (days 4 – 90)		
Skilled Nursing Facility	\$0/day (days 1 – 20); \$21-	4/day (days 21 – 100)		
Home Health	\$0 Cop	ay		
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharma DME Supplier; continuous glucose monitors, sensors and transmitters dispen 20% coinsurance for all other:	sed via retail or mail order pharmacy are limited to Abbott and Dexcom,		
Durable Medical Equipment	20% Coinsulance for all officer			
OTC	Harrisburg/Northeast: \$125 Allowance Once Per Quarter			
	Lancaster: \$120 Allowance Once Per Quarter North Central: \$140 Allowance Once Per Quarter	\$150 Allowance Once Per Quarter		
Flex Card	N/A			
Meal Benefit	N/A			
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endoc			
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and			
CHF and COPD Management powered by Vida Health care Kits	\$0 program for COPD and Congestive Heart Failure to manage condition through an lessons on symptom monitoring, and r N/A	egular mental health assessments.		
Fitness Benefit	32 credits per month; no rollover of credits	32 credits per month; no rollover of credits		
Additional Telehealth Services	Services covered with applicable			
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs			
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35			
Medicare Covered Vision (Office Visit)	\$0 Consulative up to a maximum of a 355			
Routine Vision (Office Visit)	\$0 Copay (One every year)	\$0 Copay (One every year)		
Routine Vision (Office Visit) Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. A \$200 b	onofit maximum applies to non-standard frames and a \$200 honofit maximum		
','	for specialty contact lenses. \$200 benefit	maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	\$0 Copey (Ope suprivings)			
Routine Hearing Exam	\$0 Copay (One every year)	\$0 Copay (One every year)		
Routine Hearing (Hearing Aids) Routine Dental	Two Hearing Aids every year; TruHearing Advanced – Office Visit: \$0 Copay (One every six months) Includes exam, clean			
Medicare Covered Comprehensive Dental	\$0 Cop			
Dental Allowance — Preventive and/or Comprehensive	Combined maximum a			
Comprehensive Dental — Supplemental	\$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. See EOC for be			
Madiagra Cayarad Chirapraetia				
Medicare Covered Chiropractic	\$10 Cop	pay		
Routine Chiropractic	\$10 Cop \$10 Copay (fo	pay pur visits)		
Routine Chiropractic Medicare Covered Podiatry	\$10 Cop \$10 Copay (fo \$0 Cop	pay pur visits) ay		
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$10 Cop \$10 Copay (ft \$0 Cop \$0 Copay (fc	oay vur visits) ay ur visits)		
Routine Chiropractic Medicare Covered Podiatry	\$10 Cop \$10 Copay (fo \$0 Cop	oay vur visits) ay ur visits)		
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$10 Cop \$10 Copay (fr \$0 Cop \$0 Copay (fc \$0 Copay (fc	oay vur visits) ay ur visits)		
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for	\$10 Cop \$10 Copay (fc \$0 Cop \$0 Copay (fc \$0 Cop PART D DRUGS	oay sur visits) ay ur visits) ay Lean (Performance)		
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to	\$10 Cop \$10 Copay (ft \$0 Copay (ft \$0 Copay (ft \$0 Cop \$0 Cop \$0 Cop PART D DRUGS Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, \$tandard Retail: Tier 1: \$7, Tier 2: \$15, Preferred Mail Order: Tier 1: \$0, Tier 2: \$15,	Day		
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	\$10 Cop \$10 Copay (for \$0 Copay (for \$0 Copay (for \$0 Cop \$0 Copay (for \$0 Cop PART D DRUGS Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$0, \$1 standard Retail: Tier 1: \$7, Tier 2: \$15,	Lean (Performance) Fier 3: 25%, Tier 4: 50%, Tier 5: 33% Tier 3: 25%, Tier 4: 50%, Tier 5: 33% 15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% 16, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% 16, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% 16 full cost for covered Part D drugs.		

For Agent Use Only

Community Blue Medicare PPO Signature — CPA/NEPA





Community Blue Medicare PPO Signature Harrisburg



Community Blue Medicare PPO Signature Northeast



Community Blue Medicare PPO Signature Lehigh Valley



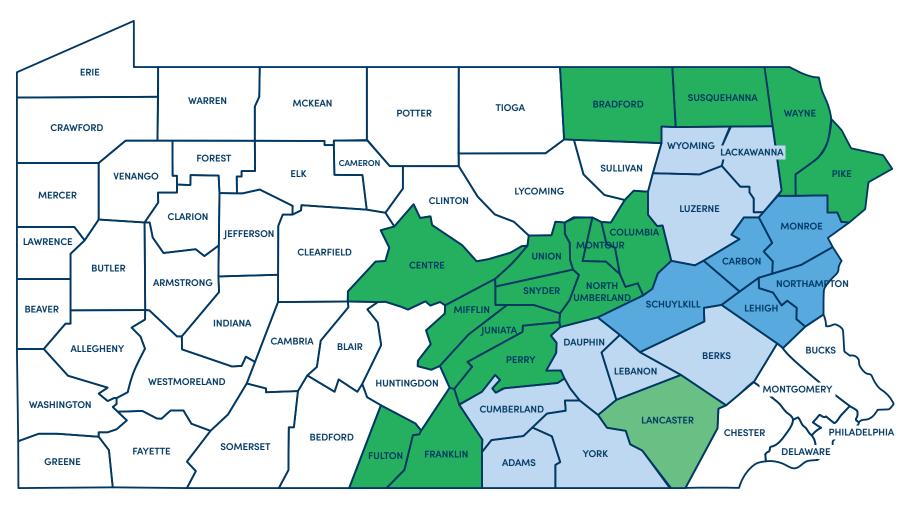
Community Blue Medicare PPO Signature Lancaster

Community Blue Medicare PPO Signature — CPA/NEPA (Products and pricing by county)

	SICNA	TIIDE		
Monthly Plan Promium	SIGNA			
Monthly Plan Premium	Lehigh Valley/Harrisburg/Northeast: \$0	Lancaster: \$0		
Part B Premium Buyback	Lehigh Valley/Harrisburg: \$24; Northeast: \$2	\$23		
Out-of-Pocket Maximum	Network: Lehigh Valley/Harrisburg: \$7,950; Northeast: \$7,550; Combined: \$10,000	Network: \$7,950; Combined: \$10,000		
PCP Office Visit Specialist Office Visit	\$0 Copay IN; \$ Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 Copay IN; \$25 Copay OON		
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$35 Copay OON			
Lab and Diagnostic Tests (Outpatient Facility)	Lohigh Valloy/Harrishura: \$10 Copay IN: \$35 Copay OON:			
	Northeast: \$0 Copay IN; \$35 Copay OON	\$10 Copay IN; \$35 Copay OON		
X-rays	\$20 Copay IN; \$50 Copay OON	\$20 Copay IN; \$50 Copay OON		
Radiation Therapy	\$60 Copay IN; \$90 Copay OON			
Advanced Imaging	Lehigh Valley/Harrisburg: \$195 Copay IN; \$325 Copay OON; Northeast: \$175 Copay IN; \$325 Copay OON	\$195 Copay IN; \$325 Copay OON		
Preventive/Screening	Covered in Full (Office visite Lehigh Valley/Harrisburg: \$35 Copay IN; \$60 Copay OON;	copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	Northeast: \$25 Copay IN; \$50 Copay OON;	\$30 Copay IN; \$60 Copay OON		
Medicare Covered Acupuncture	Lehigh Valley/Harrisburg: \$35 Copay IN; \$60 Copay OON;	\$30 Copay IN; \$60 Copay OON		
0	Northeast: \$25 Copay IN; \$50 Copay OON			
Outpatient Occupational Therapy	\$30 Copay IN; \$			
Outpatient Mental Health	\$40 Copay IN; \$			
Outpatient Substance Abuse	\$45 Copay IN; \$	50 Copay OON		
Outpatient Surgical	ASC: Lehigh Valley/Harrisburg: \$275 Copay IN; \$400 Copay OON; Northeast: \$225 Copay IN; \$400 Copay OON Facility: Lehigh Valley/Harrisburg: \$350 Copay IN; \$400 Copay OON; Northeast: \$300 Copay IN; \$400 Copay OON	ASC: \$275 Copay IN; \$400 Copay OON Facility: \$350 Copay IN; \$400 Copay OON		
Ambulance	Lehigh Valley/Harrisburg: Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON Northeast: \$350 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON		
Transportation	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip			
Emergency Room	\$110 C			
Urgent Care	\$30 Copay	\$20 Copay		
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	Lehigh Valley/Harrisburg: \$350/admit IN; \$225/day (days 1 – 7), \$0/day (days 8 – 90) OON; Northeast: \$275/admit IN; \$225/day (days 1 – 7), \$0/day (days 8 – 90) OON	\$350/admit IN; \$275/day (days 1 – 5), \$0/day (days 6 – 90) OON		
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$500/day (days 1 – 3), \$0/day (days 4 – 90) OON		
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days			
Home Health	\$0 Copay IN; 30% C			
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott an 20% Coinsurance IN: 3	d Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON		
Durable Medical Equipment OTC	Lehigh/Harrisburg: \$145 Allowance Once Per Quarter. Northeast: \$155 Allowance Once Per Quarter	\$145 Allowance Once Per Quarter		
Flex Card	N/			
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endoc			
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and			
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through a lessons on symptom monitoring, and r	ın app. Members will receive help from dietitians, health coaches, in-app trackers,		
Fitness Benefit	32 credits per month;			
Additional Telehealth Services	Services covered with applicate			
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Co			
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35 copay fo	or a one month supply of insulin IN; \$35 Copay OON		
Medicare Covered Vision (Office Visit)	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 Copay IN; \$25 Copay OON		
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copay			
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum fo	r post cataract eyewear.		
Medicare Covered Hearing Exam	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$30 Copay IN; \$30 Copay OON		
Routine Hearing Exam	Lehigh Valley/Harrisburg: \$30 Copay IN; \$30 Copay OON (One every year); Northeast: \$25 Copay IN; \$25 Copay OON (One every year)	\$25 Copay IN; \$25 Copay OON (One every year)		
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing F			
Routine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clea			
Medicare Covered Comprehensive Dental	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 Copay IN; \$25 Copay OON		
Dental Allowance — Preventive and/or Comprehensive	Combined maximum			
Comprehensive Dental — Supplemental	20% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/o 50% Coinsurance OON. So			
Medicare Covered Chiropractic	Lehigh Valley/Harrisburg: \$15 Copay IN; \$15 OON; Northeast: \$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$15 OON		
Routine Chiropractic	Lehigh Valley/Harrisburg: \$15 Copay IN; \$15 OON (four visits);	\$15 Copay IN; \$15 OON (four visits)		
Medicare Covered Podiatry	Northeast: \$15 Copay IN; \$35 Copay OON (four visits)	* * * * * * * * * * * * * * * * * * * *		
Routine Podiatry	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON (four visits); Northeast: \$20 Copay IN; \$20 Copay OON (four visits)	\$25 IN; \$25 OON \$25 Copay IN; \$25 OON (four visits)		
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 Copay IN; 320 Copay OON (four visits)	Coinsurance OON		
Carpanelli biood	PART D DRUGS			
Formulary	Lean (Perf	prmance)		
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-	Preferred Retail: Tier 1: \$7, Tier 2: \$5 Standard Retail: Tier 1: \$7, Tier 2: \$15	, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tie	3: 25%, Tier 4: 50%, Tier 5 (31-day supply): 33%		
OOP Threshold	\$2,000. Once that is met, the plan pays			
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$10:	5 for 90-day supply at a retail or mail order pharmacy		

For Agent Use Only

Community Blue Medicare PPO Distinct — CPA/NEPA





Community Blue Medicare PPO Distinct Harrisburg



Community Blue Medicare PPO Distinct Northeast



Community Blue Medicare PPO Distinct Lehigh Valley



Community Blue Medicare PPO Distinct Lancaster

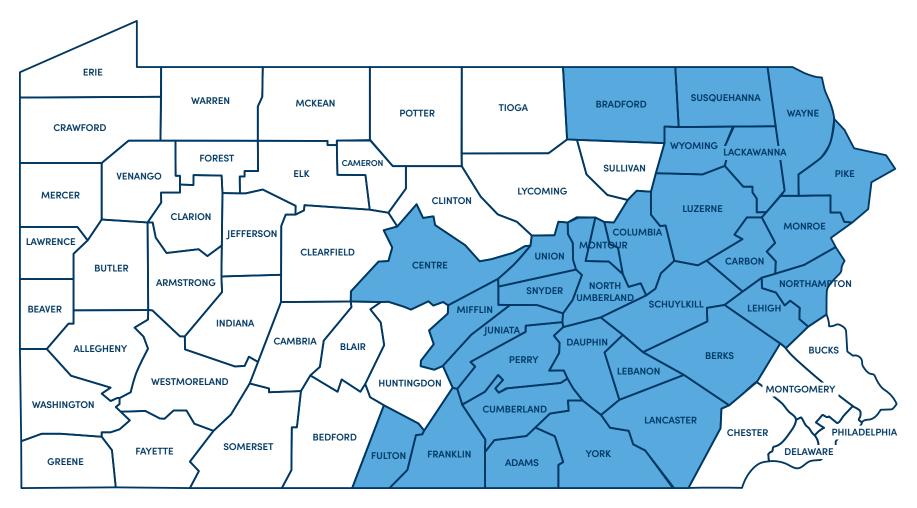
^{*}Pricing is subject to CMS approval

Community Blue Medicare PPO Distinct — CPA/NEPA (Products and pricing by county)

	DISTINCT			
Monthly Plan Premium	Lehigh Valley/Harrisburg: \$15 (\$0 Buyback); Northeast: \$15 (\$3 Buyback)	Lancaster: \$18 (\$3 Buyback)		
Out-of-Pocket Maximum	Network: \$5,500; Combined: \$8,950	Network: \$5.500; Combined: \$8.950		
PCP Office Visit	\$0 Copay IN;	SO Copay OON		
Specialist Office Visit	\$15 Copay IN; \$15 Copay OON	\$5 Copay IN; \$5 Copay OON		
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)		SO Copay OON		
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN; \$0 Copay OON			
X-rays	\$20 Copay IN; \$20 Copay OON \$15 Copay OON			
Radiation Therapy		S60 Copay OON		
Advanced Imaging		S175 Copay OON		
Preventive/Screening		copay may apply) IN/OON		
Outpatient Physical and Speech Therapy Medicare Covered Acupuncture	\$15 Copay IN; \$ \$15 Copay IN; \$	S15 Copay OON		
Outpatient Occupational Therapy		330 Copay OON		
Outpatient Mental Health		S30 Copay OON		
Outpatient Substance Abuse		S50 Copay OON		
Outpatient Surgical		acility: \$245 Copay IN; \$245 Copay OON		
Ambulance	Emergent/Non-Emergent: \$275 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON		
Transportation	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip			
Emergency Room		Copay		
Urgent Care	\$30 Copay	\$10 Copay		
Inpatient Hospital Stay	\$250/admit IN: 5	2250/admit OON		
(COVID-19 cost share waiver has been removed)	· · · · · · · · · · · · · · · · · · ·			
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$	\$425/day (days 1 – 3), \$0/day (days 4 – 90) OON		
Skilled Nursing Facility		s 21 – 100) IN; 30% Coinsurance OON Coinsurance OON		
Home Health Diabetic Supplies and Services		nacy limited to Abbott and LifeScan, all other brands are covered through a		
Diabetic Supplies and Services		ensed via retail or mail order pharmacy are limited to Abbott and Dexcom,		
	20% coinsurance for all other covered dia			
Durable Medical Equipment		30% Coinsurance OON		
отс	Lehigh Valley/Harrisburg: \$100 Allowance Once Per Quarter	\$95 Allowance Once Per Quarter		
	Northeast: \$95 Allowance Once Per Quarter			
Flex Card	N. N.			
Onduo		crinologist and receive a glucometer with an unlimited supply of test strips IN		
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs. IN			
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN			
Health care Kits	N/A			
Fitness Benefit	32 credits per month	no rollover of credits		
Additional Telehealth Services	Services covered with applica	ble Copay listed for outpatient		
Part B Drugs — Chemotherapy and All Other Part B		oinsurance for all other Part B drugs IN; 30% Coinsurance OON		
Part B Drugs — Insulin		or a one month supply of insulin IN; \$35 Copay OON		
Medicare Covered Vision (Office Visit)	\$15 Copay IN; \$15 Copay OON	\$5 Copay IN; \$5 Copay OON		
Routine Vision (Office Visit)		y OON (One every year)		
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full.	. IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	\$200 benefit maximum for specialty contact lenses \$15 Copay IN; \$15 Copay OON	\$5 Copay IN; \$5 Copay OON		
Routine Hearing Exam	\$15 Copay IN; \$15 Copay OON (One every year)	\$5 Copay IN; \$5 Copay OON (One every year)		
Routine Hearing (Hearing Aids)		Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid		
Routine Dental		six months) Includes exam, cleaning, and fluoride treatment		
	X-ray: \$0 Copay IN; 30% Coins	surance OON (One every year)		
Medicare Covered Comprehensive Dental	\$15 Copay IN; \$15 Copay OON	\$5 Copay IN; \$5 Copay OON		
Dental Allowance — Preventive and/or Comprehensive		allowance of \$3,000		
Comprehensive Dental — Supplemental	10% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (re	movable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services		
M. I. C. LOL.	(\$0 Palliative. 10% All others). 50% Coins			
Medicare Covered Chiropractic		N; \$15 OON		
Routine Chiropractic Medicare Covered Podiatry	\$15 Copay IN; \$15 \$15 IN: \$15 OON	OON (four visits) \$5 IN: \$5 OON		
Routine Podiatry	\$15 Copay IN; \$15 OON (four visits)	\$5 Copay IN; \$5 OON (four visits)		
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood		Coinsurance OON		
Salada and Full formary Remain and Self, Full full flospituit, Output lefti Blood				
	PART D DRUGS			
N-4		formance)		
Network		VS w/BPM Wrap		
Deductible	·	0		
		D, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply.				
Can get up to 100-day supply for T1 and T2 and 90-day supply for	Standard Retail: Tier 1: \$7, Tier 2: \$15	5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to	•	5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% : \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2 Standard Mail Order: Tier 1: \$21, Tier 2:	: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% \$45, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to	Preferred Mail Order: Tier 1: \$0, Tier 2 Standard Mail Order: Tier 1: \$21, Tier 2: \$2,000. Once that is met, the plan pay:	: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		

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Community Blue Medicare PPO Premier — CPA/NEPA



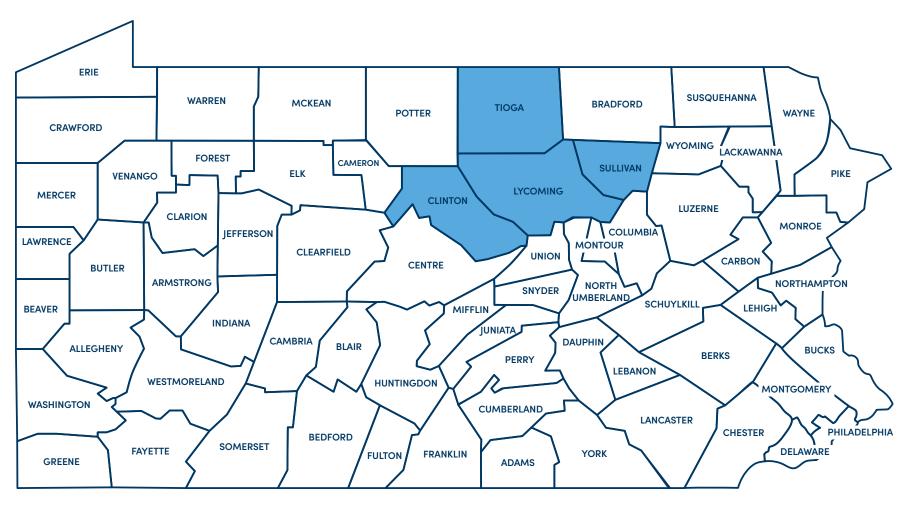
Community Blue Medicare PPO Premier

Community Blue Medicare PPO Premier - CPA/NEPA (Products and pricing by county)

	PREMIER
Monthly Plan Premium	\$55
Part B Premium Buyback	\$1
Out-of-Pocket Maximum PCP Office Visit	Network: \$4,900; Combined: \$8,950
Specialist Office Visit	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	SO COPAY IN, SO COPAY OON SO COPAY IN, SO COPAY OON
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN, \$0 Copay OON
X-rays	\$20 Copay (N), \$20 Copay OON
Radiation Therapy	\$60 Copay IN; \$60 Copay OON
Advanced Imaging	\$150 Copay IN; \$150 Copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	\$0 Copay IN; \$0 Copay OON
Medicare Covered Acupuncture	\$0 Copay IN; \$0 Copay OON
Outpatient Occupational Therapy	\$0 Copay IN; \$0 Copay OON
Outpatient Mental Health	\$30 Copay IN; \$30 Copay OON
Outpatient Substance Abuse	\$45 Copay IN; \$50 Copay OON
Outpatient Surgical	ASC: \$175 Copay IN; \$175 Copay OON; Facility: \$245 Copay IN; \$245 Copay OON
Ambulance	Emergent/Non-Emergent: \$260 IN; Non-Emergent: 30% Coinsurance OON
Transportation Emergency Prom	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER. \$125 Copay
Emergency Room Urgent Care	SIZS COPBY STS COPBY
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	S15 COPBY \$250/admit IN; \$250/admit OON
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) III); \$425/day (days 1 – 3), \$0/day (days 4 – 90) IV)
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON
Home Health	\$0 Copay IN; 30% Coinsurance OON
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a
	DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom,
	20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON
OTC	\$185 Allowance Once Per Quarter
Flex Card Onduo	N/A
Spring Health	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips IN \$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs. IN
CHF and COPD Management powered by Vida	so bendured neutral care programs and congestive Heart Failure to manage condition through an app. Members will receive help from dietitions, health coaches,
Citi and COPD Management powered by vida	in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN
Fitness Benefit	32 credits per month; no rollover of credits
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; \$35 Copay OON
Medicare Covered Vision (Office Visit)	\$0 Copay IN; \$0 Copay OON
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copay OON (One every year)
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	\$200 benefit maximum for specially contact lenses. \$200 benefit maximum for post cataract eyewear. \$0 Copay (N; \$0 Copay ON)
Routine Hearing Exam	SU Coppy (No Koppy OON (One every year)
Routine Hearing Exam Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay (N); \$500 allowance IN/OON for any other hearing aid
Routine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, cleaning, and fluoride treatment; X-ray: \$0 Copay IN;
	30% Coinsurance OON (One every year)
Medicare Covered Comprehensive Dental	\$0 Copay IN; \$0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000
Comprehensive Dental — Supplemental	\$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services.
H I' C ICI' I'	50% Coinsurance OON, See EOC for benefit limits.
Medicare Covered Chiropractic	\$20 Copay OON
Routine Chiropractic	\$20 Copay IN; \$20 Copay OON (eight visits)
Medicare Covered Podiatry Routine Podiatry	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	SU Copay (IV) Copay OUN (IU VISIRS) \$0 Copay (IN) 30% Coinsurance OON
caratac and Fullionary Kenab and SET, Furnar nospital, Outputient Blood	
	PART D DRUGS
Formulary	Lean (Performance)
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Standard Mail Order: Ter 1: \$21, Ter 2: \$45, Tier 3: \$25%, Tier 4: \$0%, Tier 5: \$3%
OOP Threshold	\$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

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Community Blue Medicare Plus PPO — NEPA





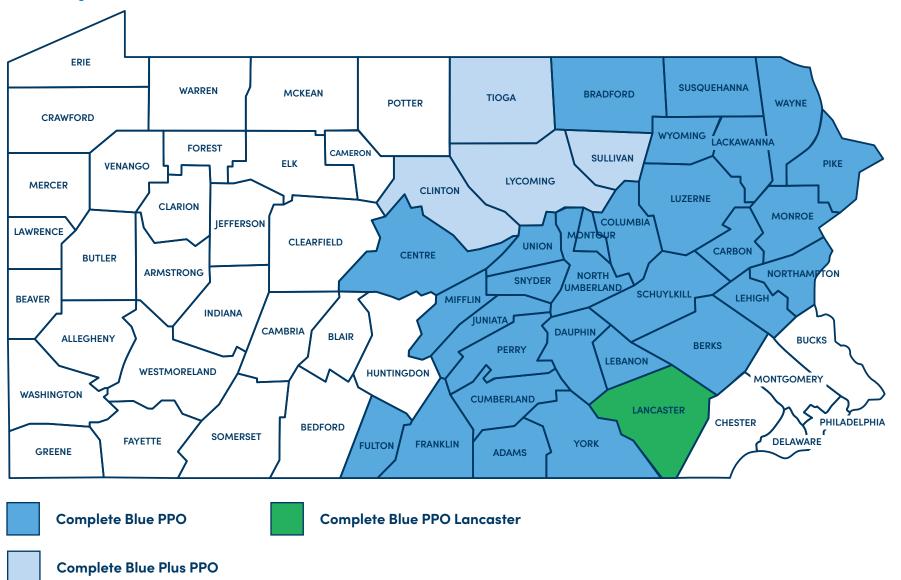
Community Blue Medicare Plus PPO

Community Blue Medicare Plus PPO - NEPA (Products and pricing by county)

	SIGNATURE	DISTINCT	PREMIER	
Monthly Plan Premium	\$0	\$20	\$55	
Part B Premium Buyback	\$20	\$0	\$2	
Out-of-Pocket Maximum	Network: \$7,950; Combined: \$10,000	Network: \$5,500; Combined: \$8,950	Network: \$4,900; Combined: \$8,950	
PCP Office Visit		\$0 Copay IN; \$0 Copay OON		
Specialist Office Visit	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	
Lab and Diagnostic Tests (Outpatient Facility)	\$10 Copay IN; \$35 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	
X-rays	\$20 Copay IN; \$50 Copay OON	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	
Radiation Therapy	\$60 Copay IN; \$90 Copay OON	\$60 Copay IN; \$60 Copay OON	\$60 Copay IN; \$60 Copay OON	
Advanced Imaging	\$195 Copay IN; \$325 Copay OON	\$175 Copay IN; \$175 Copay OON	\$150 Copay IN; \$150 Copay OON	
Preventive/Screening		Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	\$30 Copay IN; \$50 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Medicare Covered Acupuncture	\$30 Copay IN; \$50 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Outpatient Occupational Therapy	\$30 Copay IN; \$50 Copay OON	\$25 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	
Outpatient Mental Health	\$40 Copay IN; \$50 Copay OON	\$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON	
Outpatient Substance Abuse	\$45 Copay IN; \$50 Copay OON	\$45 Copay IN; \$50 Copay OON	\$45 Copay IN; \$50 Copay OON	
Outpatient Surgical	ASC: \$275 Copay IN; \$400 Copay OON	ASC: \$175 Copay IN; \$175 Copay OON	ASC: \$175 Copay IN; \$175 Copay OON	
A 1 1	Facility: \$350 Copay IN; \$400 Copay OON	Facility: \$245 Copay IN; \$245 Copay OON	Facility: \$245 Copay IN; \$245 Copay OON	
Ambulance	Emergent/Non-Emergent: \$300 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$325 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$260 IN; Non-Emergent: 30% Coinsurance OON	
Transportation		surance OON. Covered only if trip is part of continued acute care a		
Emergency Room	\$110 Copay	\$125 Copay	\$125 Copay	
Urgent Care	\$30 Copay	\$30 Copay	\$15 Copay	
Inpatient Hospital Stay		• •		
(COVID-19 cost share waiver has been removed)	\$400/admit IN; \$275/day (days 1-5), \$0/day (days 6-90) OON	\$300/admit IN; \$300/admit OON	\$250/admit IN; \$250/admit OON	
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 - 3), \$0/day (days 4 - 90) IN;	
, , , , , , , , , , , , , , , , , , , ,	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$425/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$425/day (days 1 – 3), \$0/day (days 4 – 90) OON	
Skilled Nursing Facility	\$0	D/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance O	ON .	
Home Health		\$0 Copay IN; 30% Coinsurance OON		
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail of	order pharmacy limited to Abbott and LifeScan, all other brands are	e covered through a DME Supplier; continuous glucose monitors,	
	sensors and transmitters dispensed via retail or mail order p	pharmacy are limited to Abbott and Dexcom, 20% coinsurance for	all other covered diabetic supplies IN; 30% Coinsurance OON	
Durable Medical Equipment		20% Coinsurance IN; 30% Coinsurance OON		
отс	\$165 Allowance Once Per Quarter	\$100 Allowance Once Per Quarter	\$180 Allowance Once Per Quarter	
Flex Card		N/A		
Onduo		betes. Members can see an endocrinologist and receive a glucom		
Spring Health		ital tools, coaching, in-person and virtual clinical support to help m		
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers,			
Fitness Benefit	lesso	ons on symptom monitoring, and regular mental health assessmen 32 credits per month; no rollover of credits	IS. IN	
Additional Telehealth Services		Services covered with applicable Copay listed for outpatient		
Part B Drugs — Chemotherapy and All Other Part B	0% - 19.99% Coinsurance for	Part B rebatable drugs and 20% Coinsurance for all other Part B dr	uas IN: 30% Coinsurance OON	
Part B Drugs — Insulin		up to a maximum of a \$35 copay for a one month supply of insulin I		
Medicare Covered Vision (Office Visit)	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Routine Vision (Office Visit)		\$0 Copay IN; \$50 Copay OON (One every year)		
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$150 benefit maximum applies to non-standard frames and a \$150 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.	standard frames and a \$200 benefit maximum for specialty co	vered in full. IN/OON: A \$200 benefit maximum applies to non- ntact lenses. \$200 benefit maximum for post cataract eyewear.	
Medicare Covered Hearing Exam	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Routine Hearing Exam	\$25 Copay IN; \$25 Copay OON (One every year)	\$15 Copay IN; \$15 Copay OON (One every year)	\$0 Copay IN; \$0 Copay OON (One every year)	
Routine Hearing (Hearing Aids) Routine Dental	Office Visits to Congress 12 20% Calary and a CONSTRUCTION OF The Congress 12 20% Calary and a CONSTRUCTION OF THE CONTROL OF	anced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500	allowance IN/OON for any other nearing aid	
Medicare Covered Comprehensive Dental	\$25 Copay IN; \$25 Copay OON	ery six months) Includes exam, cleaning, and fluoride treatment; X- \$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0% Coinsurance OON (One every year)	
Dental Allowance — Preventive and/or Comprehensive	S25 Copay IN; S25 Copay OON Combined maximum allowance of \$2,500	Combined maximum allowance of \$3,000	Combined maximum allowance of \$3,000	
Comprehensive Dental — Supplemental		Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surg		
Comprehensive Demai — Supplemental	20% Comparance. Residiative Services, Endodonilics, Periodonilics	50% Coinsurance OON. See EOC for benefit limits.	ory, and hajanenive deneral dervices (30 Familiarive, 20% All Offices).	
Medicare Covered Chiropractic	\$15 Copay IN; \$15 Copay OON	\$15 Copay IN; \$15 Copay OON	\$20 Copay IN; \$20 Copay OON	
Routine Chiropractic	\$15 Copay IN; \$15 Copay OON (four visits)	\$15 Copay IN; \$15 Copay OON (four visits)	\$20 Copay IN; \$20 Copay OON (eight visits)	
Medicare Covered Podiatry	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON	
Routine Podiatry	\$25 Copay IN; \$25 Copay OON (four visits)	\$15 Copay IN; \$15 Copay OON (four visits)	\$0 Copay IN; \$0 Copay OON (10 visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital,		\$0 Copay IN; 30% Coinsurance OON		
Outpatient Blood	PART D	DRUGS		
Formulary	Lean (Performance)	Lean (Performance)	Lean (Performance)	
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 48%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 48%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 48%, Tier 5: 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 48%, Tier 5: 33%	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	
OOP Threshold	\$2,00	00. Once that is met, the plan pays the full cost for covered Part D o	rugs.	
IRA Benefits – T3 and T4	Tier 3 and Tier 4 Insul	lins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or	mail order pharmacy	
offered through ICP and Coverage Gap stages		, , , , , , , , , , , , , , , , , , , ,	·	

For Agent Use Only

New! Complete Blue PPO and Complete Blue Plus PPO — CPA/NEPA



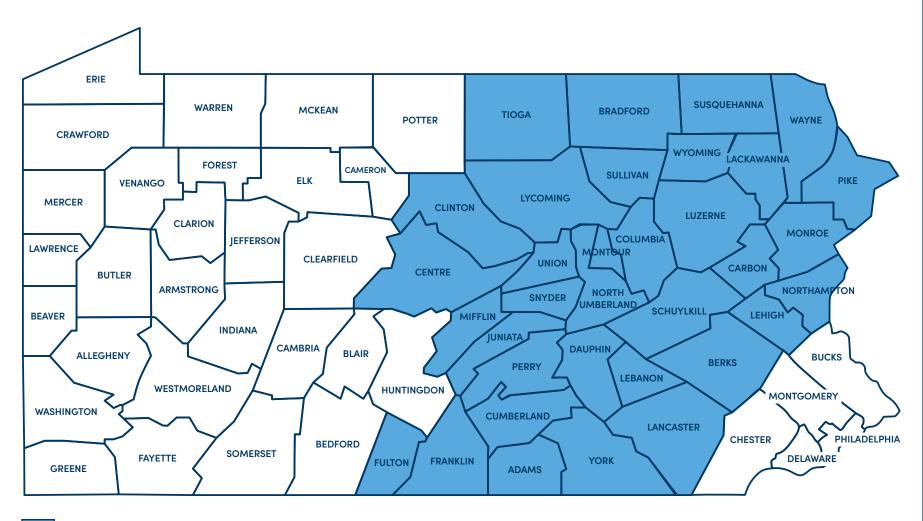
^{*}Pricing is subject to CMS approval

New! Complete Blue PPO and Complete Blue Plus PPO — CPA/NEPA (Products and pricing by county)

	NEW! CHOICE	NEW! CHOICE DELUXE			
Monthly Plan Premium	\$0	\$7			
Part B Premium Buyback	\$19	\$0			
Out-of-Pocket Maximum	Network: \$7,550; Combined: \$10,000	Network: \$6,400; Combined: \$8,950			
PCP Office Visit	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON			
Specialist Office Visit	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON			
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$0 Copay OON			
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$0 Copay OON			
X-rays	\$25 Copay IN; \$50 Copay OON	\$20 Copay IN; \$20 Copay OON			
Radiation Therapy	\$75 Copay IN; \$90 Copay OON	\$75 Copay IN; \$75 Copay OON			
Advanced Imaging	\$250 Copay IN; \$325 Copay OON \$295 Copay IN; \$295 Copay OON				
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON				
Outpatient Physical and Speech Therapy	\$25 Copay IN; \$50 Copay OON	\$20 Copay IN; \$20 Copay OON			
Medicare Covered Acupuncture	\$25 Copay IN; \$50 Copay OON	\$20 Copay IN; \$20 Copay OON			
Outpatient Occupational Therapy Outpatient Mental Health	\$25 Copay IN; \$60 Copay OON \$40 Copay IN; \$60 Copay OON	\$20 Copay IN; \$20 Copay OON \$30 Copay IN; \$30 Copay OON			
Outpatient Substance Abuse	\$45 Copay IN; \$60 Copay OON	\$45 Copay IN; \$50 Copay OON			
Outpatient Surgical	ASC: \$250 Copay IN; \$350 Copay OON	ASC: \$250 Copay IN; \$250 Copay OON			
Outputient surgicul	Facility: \$350 Copay IN; \$400 Copay OON	Facility: \$350 Copay IN; \$350 Copay OON			
Ambulance	Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$280 IN; Non-Emergent: 30% Coinsurance OON			
Transportation	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip				
Emergency Room	\$110 Copay	\$125 Copay			
Urgent Care	\$30 Copay	\$50 Copay			
Inpatient Hospital Stay	\$170/day (days 1 – 3) IN, \$0/day (days 4 – 90) IN;	\$415/admit IN; \$415/admit OON			
	\$300/day (days 1 – 7), \$0/day (days 8 – 90) OON	·			
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$425/day (days 1 – 3), \$0/day (days 4 – 90) OON			
Skilled Nursing Facility	\$0/day (days 1 – 3), \$0/day (days 4 – 90) OON \$0/day (days 1 – 20): \$214/day (days	y (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON			
Home Health					
Diabetic Supplies and Services	\$0 Copay IN; 30% Coinsurance OON 0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a				
Diazone dappinos ana dor vidos	DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom,				
	20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON				
Durable Medical Equipment	20% Coinsurance IN; 3				
OTC	Covered in Flex Card benefit	Covered in Flex Card benefit			
Flex Card	Dental, Vision, Hearing, OTC — \$450	Dental, Vision, Hearing, OTC — \$455 (Lancaster and Complete Blue Plus PPO: \$450)			
	, , ,	Part B — \$200 (\$50 Transaction Limit)			
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips IN				
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs. IN				
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN				
Fitness Benefit	in-app irackers, iessons on symptom monitoring, and regular mental nealin assessments. In				
Additional Telehealth Services	Services covered with applical				
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% C				
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35 copay f				
Medicare Covered Vision (Office Visit)	\$30 Copay IN; \$30 Copay OON				
Routine Vision (Office Visit)					
	\$0 Copay IN: \$50 Copay	\$25 Copay IN; \$25 Copay OON			
	\$0 Copay IN; \$50 Copay	\$25 Copay IN; \$25 Copay OON OON (One every year)			
Routine Vision (Eyewear)	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a			
Routine Vision (Eyewear) Medicare Covered Hearing Exam	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year)	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year)			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, cle	\$25 Copay IN; \$25 Copay OON 'OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Ining, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year)			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Alds Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clea	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing IOffice Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, cless \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clec \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics	\$25 Copay IN; \$25 Copay OON 'OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing In Office Visit: \$0 Copay IN; \$30 Copay IN;	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Ining, and fluoride treatment; X-roy: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing IOffice Visit: \$0 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services \$50 Copay IN; \$30 Copay IN; \$30 Copay IN; \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (s0 Palliative, 50% All others).	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 \$0% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative, \$50% All others).			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, cles \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 \$50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$35 OON	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$25 Copay OON \$15 Copay IN; \$25 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray; \$0 Copay IN; \$30° Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 50% Coinsurance: Restorative Services, Endodontics, Peroidontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$15 OON			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clee \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 50% Coinsurance: Restorative Services, Endodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$35 COpay OON (four visits)	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Ining, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$15 Copay ONN (four visits)			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; \$30 Copay OON (One every six months) Includes exam, clee \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$35 COPAY OON \$15 Copay IN; \$35 COPAY OON \$30 COPAY IN; \$35 COPAY OON \$30 COPAY IN; \$30 COPAY OON	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 \$0% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. \$50% All others). \$15 Copay IN; \$15 COPA \$15 Copay IN; \$25 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON \$20 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clee \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 50% Coinsurance: Restorative Services, Endodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$35 COpay OON (four visits)	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$25 Copay OON S15 Copay IN; \$25 Copay OON Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 Combined maximum allowance of \$5,000 \$0% Coinsurance: Restorative Services, Endodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON			
Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$0 Copay IN; \$50 Copay Standard Eyeglass lenses and frames or contact lenses are covered in full. \$200 benefit maximum for specialty contact lenses \$30 Copay IN; \$30 Copay OON \$20 Copay IN; \$20 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing I Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, clec \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$3,500 50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (S0 Palliative. 50% All others). \$15 Copay IN; \$35 COPAY \$15 Copay IN; \$35 COPAY \$30 COPAY IN; \$30 COPAY \$30 COPAY IN; \$30 COPAY OON \$50 COPAY IN; \$30 COPAY OON	\$25 Copay IN; \$25 Copay OON OON (One every year) IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for post cataract eyewear. \$25 Copay IN; \$25 Copay OON \$15 Copay IN; \$15 Copay OON (One every year) Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid uning, and fluoride treatment; X-ray: \$0 Copay IN; \$30 Coinsurance OON (One every year) \$25 Copay IN; \$25 Copay OON Combined maximum allowance of \$5,000 50% Coinsurance: Restorative Services, Endodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). \$15 Copay IN; \$15 Copay OON (four visits) \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON			
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For Agent Use Only

Freedom Blue PPO



Freedom Blue PPO

Freedom Blue PPO — (Products and pricing by county)

	BASIC	VALUERx	STANDARD	DELUXE
Monthly Plan Premium	\$66	\$39	\$134	\$248
Part B Premium Buyback	\$0	\$0	\$0	\$0
Out-of-Pocket Maximum	Network: \$5,900; Combined: \$8,950	Network: \$5,500; Combined: \$8,950	Network: \$5,000; Combined: \$8,950	Network: \$4,500; Combined: \$8,950
PCP Office Visit	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Specialist Office Visit	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$15 Copay OON	\$0 Copay IN; \$10 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$15 Copay IN; \$15 Copay OON	\$10 Copay IN; \$10 Copay OON
X-rays	\$25 Copay IN; \$25 Copay OON	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON
Radiation Therapy		\$60 Copay IN; \$	660 Copay OON	
Advanced Imaging	\$150 Copay IN; \$150 Copay OON	\$175 Copay IN; \$175 Copay OON	\$125 Copay IN; \$125 Copay OON	\$75 Copay IN; \$75 Copay OON
Preventive/Screening		Covered in Full (Office visit	copay may apply) IN/OON	
Outpatient Physical, Speech and Occupational	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Therapy, Mental Health, and Substance Abuse	1 1 1 1			
Medicare Covered Acupuncture Outpatient Surgical	\$35 Copay IN; \$35 Copay OON ASC: \$100 Copay IN; \$100 Copay OON	\$40 Copay IN; \$40 Copay OON ASC: \$200 Copay IN; \$200 Copay OON	\$35 Copay IN; \$35 Copay OON ASC: \$150 Copay IN; \$150 Copay OON	\$30 Copay IN; \$30 Copay OON ASC: \$100 Copay IN; \$100 Copay OON
, ,	Facility: \$200 Copay IN; \$200 Copay OON	Facility: \$225 Copay IN; \$225 Copay OON	Facility: \$200 Copay IN; \$200 Copay OON	Facility: \$175 Copay IN; \$175 Copay OON
Ambulance	Emergent/Non-Emergent: \$125 IN;	Emergent/Non-Emergent: \$260 IN;	Emergent/Non-Emergent: \$215 IN;	Emergent/Non-Emergent: \$140 IN;
T	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
Transportation Emergency Room	\$0 Copay IN; 30	% Coinsurance OON. Up to 24 One-way trips. Trip limit	t waived it trip is part of continued acute care after als Copay	scharge from Ek.
Urgent Care	\$50 Copay	\$125 C \$5 Copay	\$5 Copay	\$5 Copay
Inpatient Hospital Stay		\$245/day (days 1 – 5), \$0/day (days 6 – 90) IN;		
(COVID-19 cost share waiver has been removed)	\$340/admit IN; \$340/admit OON	\$245/day (days 1 – 5), \$0/day (days 6 – 90) NN \$245/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$475/admit IN; \$475/admit OON	\$235/admit IN; \$235/admit OON
Inpatient Psychiatry Stay	\$340/admit IN; \$340/admit OON	\$245/day (days 1 - 5), \$0/day (days 6 - 90) IN; \$245/day (days 1 - 5), \$0/day (days 6 - 90) OON	\$475/admit IN; \$475/admit OON	\$235/admit IN; \$235/admit OON
Skilled Nursing Facility			s 21 – 100) IN: 30% Coinsurance OON	
Home Health	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON \$0 Copay IN; 30% Coinsurance OON			
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON			
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Flex Card			/A	
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips IN			
Spring Health		re program with digital tools, coaching, in-person and		
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN			
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON			
Meal Benefit	28 Meals/14 Days IN/OON upon discharge from an inpatient hospital stay, inpatient hospital psychiatric stay, or SNF stay to the home to qualify			
Health care Kits	N/A			
Fitness Benefit			no rollover of credits	
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient			
Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON 20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; \$35 Copay OON			
Medicare Covered Vision (Office Visit)	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Routine Vision (Office Visit)	\$35 Copay IN; \$35 Copay OON		y OON (One every year)	\$30 Copay IN; \$30 Copay OON
Routine Vision (Clince Visit) Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or conto	act lenses are covered in full. IN/OON: A \$225 benefit n	naximum applies to non-standard frames and a \$225	benefit maximum for specialty contact lenses.
Medicare Covered Hearing Exam	\$35 Copay IN; \$35 Copay OON	\$200 benefit maximum fo \$40 Copay IN; \$40 Copay OON	st Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Routine Hearing Exam	\$35 Copay IN; \$35 Copay OON \$0 Copay IN; \$35 Copay OON (One every year)	\$40 Copay IN; \$40 Copay OON \$0 Copay IN; \$40 Copay OON (One every year)	\$35 Copay IN; \$35 Copay OON \$0 Copay IN; \$35 Copay OON (One every year)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$30 Copay OON (One every year)
Routine Hearing (Hearing Aids)		\$599 copay; TruHearing Premium — \$899 copay IN;		2 Hearing Aids Every year; TruHearing Advanced — \$399 copay; TruHearing Premium — \$699 copay IN;
		•	,	\$500 allowance IN/OON for any other hearing aid
Routine Dental		315 Copay IN; 30% Coinsurance OON (One every six mo		
Medicare Covered Comprehensive Dental	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Comprehensive Dental — Supplemental	620 C INL 620 C		Services (Palliative) IN; 30% OON	620 C INI. 620 C
Medicare Covered Chiropractic Routine Chiropractic	\$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (eight visits)	\$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (six visits)	\$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (eight visits)	\$20 Copay IN; \$20 Copay OON \$20 Copay IN; \$20 Copay OON (10 visits)
Medicare Covered Podiatry	\$20 Copay IN; \$20 Copay OON (eight visits) \$35 Copay IN; \$35 Copay OON	\$20 Copay IN; \$20 Copay OON (six visits) \$40 Copay IN; \$40 Copay OON	\$20 Copay IN; \$20 Copay OON (eight visits) \$35 Copay IN; \$35 Copay OON	\$20 Copay IN; \$20 Copay OON (10 visits) \$30 Copay IN; \$30 Copay OON
Routine Podiatry	\$35 Copay IN; \$35 Copay OON \$35 Copay IN; \$35 Copay OON (10 visits)	\$40 Copay IN; \$40 Copay OON (eight visits)	\$35 Copay IN; \$35 Copay OON \$35 Copay IN; \$35 Copay OON (10 visits)	\$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (12 visits)
Cardiac and Pulmonary Rehab and SET,	(10 visits)			230 Copay III, 230 Copay OON (12 VISITS)
Partial Hospital, Outpatient Blood	\$0 Copay IN; 30% Coinsurance OON			
		PART D DRUGS		
Formulary	N/A	Lean (Performance)	Base (Venture)	Base (Venture)
	IN/A	Lean (Performance)	Buse (Veniure)	
Initial Coverage Limit. Retail: Cost sharing is for up to 31–day supply. Can get up to 100–day supply for T1 and T2 and 90–day supply for T3 and T4 at 3x	N/A		d Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, T d Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, T	
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and	N/A	Standard Prefered Mail Orde		ier 5: 33% (31-day supply): 33%
Initial Coverage Limit. Retail: Cost sharing is for up to 31–day supply. Can get up to 100–day supply for T1 and T2 and 90–day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100–day supply for T1 and T2 and up to a 90–day supply for T3 and T4, except Specialty tier (up to 31–days supply)	N/A	Standard Prefered Mail Orde Standard Mail Orde	d Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, T er: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115, Tier 4: \$275, Tier 5 r: Tier 1: \$15, Tier 2: \$57, Tier 3: \$141, Tier 4: \$300, Tier 5	(31-day supply): 33% (31-day supply): 33%
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and		Standard Prefered Mail Orde Standard Mail Orde \$2,000. Ond	d Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, T	ier 5: 33% (31-day supply): 33% (31-day supply): 33% art D drugs.

CPA/NEPA Growth Product Highlights

NEW PLAN

Complete Blue PPO Choice

All CPA and NEPA counties

\$0 plan with generous core medical benefits and a flex card to give members options for how they spend their healthcare dollars.

- \$0 PCP IN and OON
- \$0 Labs IN
- \$450 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- \$3,500 dental allowance

Community Blue Medicare PPO Signature

All CPA and NEPA counties

Fundamental \$0 plan with robust benefit, no deductible, and extras like dental, OTC, fitness, and more.

- \$0 PCP IN and OON
- \$0 Labs IN
- \$0 Tier 1 drugs
- \$2,500 dental allowance with low coinsurance IN

NEW PLAN

Complete Blue PPO Choice Deluxe

All CPA and NEPA counties

Low-priced plan with generous core medical and flex card for Part B and supplemental benefits allows members to determine how to spend their healthcare dollars.

- \$0 PCP and Labs IN and OON
- Per stay inpatient hospital
- \$450 or \$455 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- Additional \$200 Flex allowance for most Part B outpatient copays
- \$5,000 Dental allowance

Community Blue Medicare PPO Distinct

All CPA and NEPA counties

Low-priced plan for members who prefer lower and more predictable out-of-pocket costs and enhanced supplemental allowances.

- \$0 PCP and labs IN and OON
- Same cost sharing for specialist and PT, in- or out-of-network
- Per stay inpatient hospital
- \$3,000 dental allowance with low coinsurance IN
- \$0 Tier 1 and 2 drugs

Community Blue Medicare PPO Premier

All CPA and NEPA counties

Mid-priced plan offers most generous MA benefits and lowest out-of-pocket costs. Great for Medigap switchers and consumers looking for peace of mind at an affordable premium.

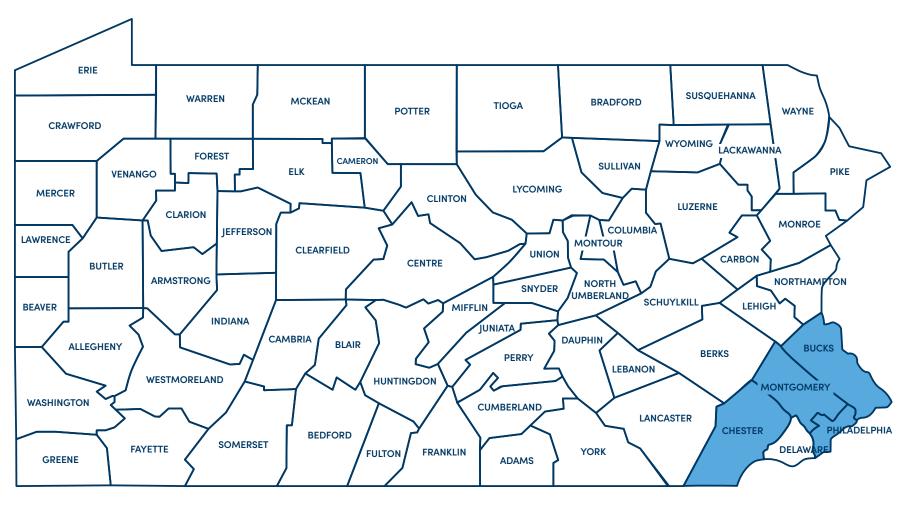
- Low OOP Max
- \$0 PCP, specialist, labs, and PT both IN and OON
- Per stay inpatient hospital
- \$3.000 first \$ dental and no coinsurance IN
- \$0 Tier 1 and 2 drugs

All PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals.

All Community Blue Medicare Plus PPO and Complete Blue Plus PPO members have exclusive in-network access to Geisinger Medical Center — Danville.

For Agent Use Only

New! Complete Blue PPO — SEPA



C

Complete Blue PPO

New! Complete Blue PPO — SEPA (Products and pricing by county)

	NEW! CHOICE DELUXE	NEW! PREMIER		
Monthly Plan Premium	\$9	\$38		
Part B Premium Buyback	\$0	\$0		
Out-of-Pocket Maximum	Network: \$6,750; Combined: \$9,550	Network: \$6,100; Combined: \$8,950		
PCP Office Visit	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON		
Specialist Office Visit	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$25 Copay IN; \$25 Copay OON \$0 Copay IN; \$0 Copay OON	\$20 Copay IN; \$20 Copay OON \$0 Copay IN; \$0 Copay OON		
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON		
X-rays	\$30 Copay IN; \$30 Copay OON	\$15 Copay IN; \$15 Copay OON		
Radiation Therapy	\$75 Copay IN; \$75 Copay OON	\$50 Copay IN; \$50 Copay OON		
Advanced Imaging	\$300 Copay IN; \$300 Copay OON	\$225 Copay IN; \$225 Copay OON		
Preventive/Screening		copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	\$25 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON		
Medicare Covered Acupuncture	\$25 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON		
Outpatient Occupational Therapy	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Outpatient Mental Health	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON		
Outpatient Substance Abuse	\$45 Copay IN; \$50 Copay OON	\$30 Copay IN; \$30 Copay OON		
Outpatient Surgical	ASC: \$200 Copay IN; \$200 Copay OON	ASC: \$150 Copay IN; \$150 Copay OON		
	Facility: \$300 Copay IN; \$300 Copay OON	Facility: \$250 Copay IN; \$250 Copay OON		
Ambulance	Emergent/Non-Emergent: \$290 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON		
Transportation		is part of continued acute care after discharge from ER.		
Emergency Room	\$125 Copay			
Urgent Care	\$50 Copay	\$15 Copay		
Inpatient Hospital Stay	\$425/admit IN; \$425/admit OON	\$425/admit IN; \$425/admit OON		
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$300/admit IN; \$300/admit OON		
	\$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	•		
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON			
Home Health	\$0 Copay IN; 30% Coinsurance OON			
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON			
Durable Medical Equipment		30% Coinsurance OON		
OTC	Covered in Flex Card benefit	\$75 Allowance Once Per Quarter		
Flex Card	Dental, Vision, Hearing, OTC — \$485; Part B — \$200 (\$50 Transaction Limit)	N/A		
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endo	crinologist and receive a glucometer with an unlimited supply of test strips IN		
Spring Health	\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs. IN			
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN			
Fitness Benefit	32 credits per month; no rollover of credits			
Additional Telehealth Services		ble Copay listed for outpatient		
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON			
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN, \$35 Copay OON			
Medicare Covered Vision (Office Visit)	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copa	y OON (One every year)		
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$200 benefit maximum applies to non-standard frames and a \$200 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.			
Medicare Covered Hearing Exam	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Routine Hearing Exam	\$15 Copay IN; \$15 Copay OON (One every year)	\$0 Copay IN; \$0 Copay OON (One every year)		
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid			
Routine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six months) Includes exam, cle	aning, and fluoride treatment; X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$4,000	Combined maximum allowance of \$3,000		
Comprehensive Dental — Supplemental	50% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative. 50% All others). 50% Coinsurance OON. See EOC for benefit limits.			
Medicare Covered Chiropractic	\$15 Copay IN; \$15 OON	\$20 Copay IN; \$20 Copay OON		
Routine Chiropractic	\$15 Copay IN; \$15 Copay OON (four visits)	\$20 Copay IN; \$20 Copay OON (four visits)		
Medicare Covered Podiatry	\$25 Copay IN; \$25 Copay OON	\$20 Copay IN; \$20 Copay OON		
Routine Podiatry	\$25 Copay IN; \$25 Copay OON (four visits)	\$20 Copay IN; \$20 Copay OON (four visits)		
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood		Coinsurance OON		
, and a second s	PART D DRUGS			
Formulary	Lean (Performance)	Lean (Performance)		
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to	Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Standard Mail: Tier 1: \$21, Tier 2: \$60, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Standard Mail: Tier 1: \$21, Tier 2: \$60, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%		
a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) OOP Threshold IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	\$2,000. Once that is met, the plan pay	Standard Mail: Her 1: \$21, Her 2: \$60, Her 3: 25%, Her 4: 50%, Her 5: 33% is the full cost for covered Part D drugs. 15 for 90-day supply at a retail or mail order pharmacy		

SEPA Growth Product Highlights

NEW PLAN

Complete Blue PPO Choice Deluxe

Bucks, Chester, Montgomery, and Philadelphia counties Low-priced plan with strong core medical benefits and a flex card that allows members to determine how to spend their healthcare dollars.

- \$0 PCP and lab IN and OON
- Same IN or OON cost-sharing for most medical benefits
- \$485 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- Additional \$200 Flex allowance for most Part B outpatient copays
- \$4,000 dental allowance
- \$0 Tier 1 drugs

NEW PLAN

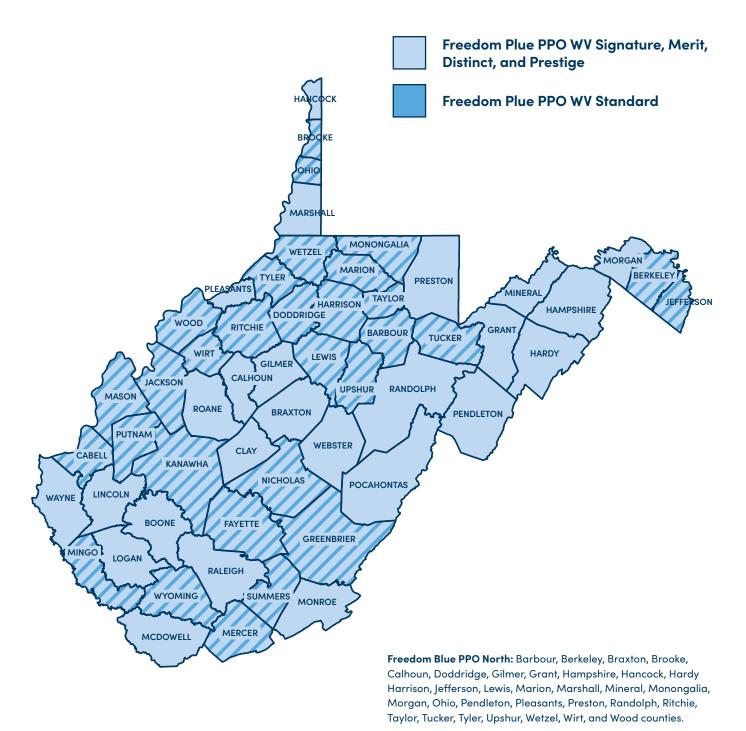
Complete Blue PPO Premier

Bucks, Chester, Montgomery, and Philadelphia counties Mid-priced plan for those who want the lowest out-of-pocket costs including \$0 copays on several core benefits and the strongest supplemental benefits. Great for Medigap switchers and consumers looking for predictability at an affordable premium.

- \$0 PCP and lab IN and OON
- \$0 PT IN
- Same IN or OON cost-sharing for most medical benefits
- Per stay inpatient hospital
- \$15 urgent Care
- \$3,000 first \$ dental allowance IN
- \$0 Tier 1 drugs

PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals

Freedom Blue PPO — WV



^{*}Pricing is subject to CMS approval

Freedom Blue PPO South: Boone, Cabell, Clay, Fayette, Greenbrier, Jackson, Kanawha, Lincoln, Logan, Mason, McDowell, Mercer, Mingo, Monroe, Nicholas, Pocahontas, Putnam, Raleigh, Roane Summers,

Wayne, Webster, and Wyoming counties.

Freedom Blue PPO - WV (Products and pricing by county)

	MERIT	SIGNATURE
Monthly Plan Premium	\$0	\$0
Part B Premium Buyback	North: \$76/South: \$99	North: \$3/South: \$4
Out-of-Pocket Maximum Medical Deductible	Network: \$8,300; Combined: \$13,000	Network: \$7,000; Combined: \$10,000
(+ indicates deductible applies before cost sharing)	North: \$150/South: \$50	N/A
PCP Office Visit	\$0 Copay IN; \$0 Copay OON+	\$0 Copay IN; \$0 Copay OON
Specialist Office Visit	North: \$45 Copay IN; \$65 Copay OON+ South: \$35 Copay IN; \$65 Copay OON+	\$25 Copay IN; \$25 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay (lab) IN; \$0 copay (diagnostic) IN+; \$100 Copay OON+	\$0 Copay IN; \$20 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$100 Copay (lab) IN; \$100 Copay (diagnostic) IN+; \$100 Copay OON+	\$10 Copay IN; \$20 Copay OON
X-rays	\$75 Copay IN+; \$100 Copay OON+ Deductible does not apply to diagnostic mammograms IN	\$25 Copay IN; \$40 Copay OON
Radiation Therapy	\$60 Copay IN+; \$75 Copay OON+	\$60 Copay IN; \$75 Copay OON
Advanced Imaging	\$300 Copay IN+; \$350 Copay OON+	\$250 Copay IN; \$350 Copay OON
Preventive/Screening Outpatient Physical and Speech Therapy	Covered in Full (Office visit North: \$45 Copay IN+; \$55 Copay OON+	copay may apply) IN/OON
Medicare Covered Acupuncture	South: \$25 Copay IN+; \$55 Copay OON+ North: \$45 Copay IN+; \$55 Copay OON+	\$30 Copay IN; \$50 Copay OON
Outpatient Occupational Therapy	South: \$25 Copay IN+; \$55 Copay OON+ North: \$35 Copay IN+; \$50 Copay OON+	\$30 Copay IN; \$50 Copay OON
	South: \$25 Copay IN+; \$50 Copay OON+	\$30 Copay IN; \$50 Copay OON
Outpatient Mental Health Outpatient Substance Abuse	\$40 Copay IN+; \$50 Copay OON+ \$40 Copay IN+; \$50 Copay OON+	\$40 Copay IN; \$50 Copay OON \$40 Copay IN; \$50 Copay OON
Outpatient Surgical	ASC: \$300 Copay IN+; \$375 Copay OON+	340 copay in, 330 copay con
	Deductible does not apply to diagnostic colonoscopy IN Facility: \$350 Copay IN; \$375 Copay OON Deductible does not apply to diagnostic colonoscopy IN	ASC: \$250 Copay IN; \$350 Copay OON Facility: \$300 Copay IN; \$350 Copay OON
Ambulance	Emergent/Non-Emergent: North: \$215 IN / South: \$150 IN Non-Emergent: 30% Coinsurance OON+	Emergent/Non-Emergent: \$275 IN Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	\$110 Copay	\$110 Copay
Urgent Care Inpatient Hospital Stay	\$45 Copay North: \$455/day (days 1 – 5), \$0/day (days 6 – 90) IN+;	\$35 Copay
(COVID-19 cost share waiver has been removed)	\$550/day (days 1 – 5), \$0/day (days 6 – 90) OON+ South: \$400/day (days 1 – 5), \$0/day (days 6 – 90) IN+; \$550/day (days 1 – 5), \$0/day (days 6 – 90) OON+	\$250/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$425/day (days 1 – 5), \$0/day (days6 – 90) OON
Inpatient Psychiatry Stay	\$645/day (days 1 – 3), \$0/day (days 4 – 90) IN+; \$645/day (days 1 – 7), \$0/day (days 8 – 90) OON+	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$500/day (days 1 – 3), \$0/day (days 4 – 90) OON
Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN+; 30% Coinsurance OON+	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON
Home Health	\$0 Copay IN+; 30% Coinsurance OON+	\$0 Copay IN; 30% Coinsurance OON
Diabetic Supplies and Services	covered through a DME Supplier; continuous glucose monitors, ser	der pharmacy limited to Abbott and LifeScan, all other brands are not and transmitters dispensed via retail or mail order pharmacy other covered diabetic supplies IN; 30% Coinsurance OON
Durable Medical Equipment OTC	20% Coinsurance IN+; 30% Coinsurance OON+ N/A	20% Coinsurance IN; 30% Coinsurance OON North: \$150 Allowance Once Per Quarter South: \$140 Allowance Once Per Quarter
Flex Card	N/A	N/A
Meal Benefit	N/A	N/A
Onduo		ers can see an endocrinologist and receive a glucometer upply of test strips IN
Spring Health		coaching, in-person and virtual clinical support to help avioral health needs. IN
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage co	ondition through an app. Members will receive help from dietitians, monitoring, and regular mental health assessments. IN
Fitness Benefit		; no rollover of credits
Additional Telehealth Services		ble Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON+	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON
Part B Drugs — Insulin		for a one month supply of insulin IN; \$35 Copay OON
Medicare Covered Vision (Office Visit)	North: \$45 Copay IN; \$65 Copay OON+ South: \$35 Copay IN; \$65 Copay OON+	\$25 Copay IN; \$25 Copay OON
Routine Vision (Office Visit)		y OON (One every year)
Routine Vision (Eyewear)		d in full. IN/OON: A \$150 benefit maximum applies to non-standard lenses. \$200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	North: \$45 Copay IN; \$65 Copay OON+ South: \$35 Copay IN; \$65 Copay OON+	\$25 Copay IN; \$25 Copay OON
Routine Hearing Exam	\$40 Copay IN; \$40 Copay OON (One every year)	\$25 Copay IN; \$25 Copay OON (One every year)
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid
Routine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every six month	ths) Includes exam, cleaning and flouride treatment X-ray: \$0 Copay OON (One every year)
Medicare Covered Comprehensive Dental	North: \$45 Copay IN; \$65 Copay OON+ South: \$35 Copay IN; \$65 Copay OON+	\$30 Copay IN; \$30 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$1,000	Combined maximum allowance of \$2,000
Comprehensive Dental — Supplemental		movable and/or fixed), Oral/Maxillofacial Surgery: 20% Coinsurance surance IN. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	\$15 Copay IN+; \$40 Copay OON+	\$15 Copay IN; \$40 OON
Routine Chiropractic Medicare Covered Podiatry	\$15 Copay IN; \$40 Copay OON (four visits) North: \$45 Copay IN; \$65 Copay OON+	\$15 Copay IN; \$40 OON (eight visits) \$25 Copay IN; \$25 Copay OON
Routine Podiatry	South: \$35 Copay IN; \$65 Copay OON+ North: \$45 Copay IN; \$65 Copay OON (8 visits)	\$25 Copay IN; \$25 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital,	South: \$35 Copay IN; \$65 Copay OON (8 visits) Cardiac Rehab: \$15 Copay IN+; 30% Coinsurance OON+	725 Sapay III, 725 Copay Cora (To visite)
Outpatient Blood	Partial Hospital: \$60 Copay IN+; 30% Coinsurance OON+ Outpatient Blood: \$0 Copay IN+; 30% Coinsurance OON+	\$0 Copay IN; 30% Coinsurance OON

DISTINCT	PRESTIGE	STANDARD
North: \$14/South: \$11	\$29	\$134
North: \$0/South: \$1	\$0	\$0
Network: \$5,700; Combined: \$9,550	Network: \$5,300; Combined: \$8,950	Network: \$6,500; Combined: \$10,000
N/A	N/A	N/A
\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$10 Copay OON
\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON
\$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$35 Copay OON	\$25 Copay IN; \$25 Copay OON
\$60 Copay IN; \$75 Copay OON	\$60 Copay IN; \$75 Copay OON	\$60 Copay IN; \$60 Copay OON
\$200 Copay IN; \$350 Copay OON	\$150 Copay IN; \$350 Copay OON Covered in Full (Office visit copay may apply) IN/OON	\$75 Copay IN; \$75 Copay OON
\$25 Copay IN; \$30 Copay OON	\$20 Copay IN; \$30 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$30 Copay OON	\$20 Copay IN; \$30 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$30 Copay OON	\$20 Copay IN; \$30 Copay OON	\$35 Copay IN; \$35 Copay OON
\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON	\$35 Copay IN; \$35 Copay OON
\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON	\$35 Copay IN; \$35 Copay OON
ASC: \$225 Copay IN; \$350 Copay OON Facility: \$300 Copay IN; \$350 Copay OON	ASC: \$225 Copay IN; \$350 Copay OON Facility: \$300 Copay IN; \$350 Copay OON	ASC: \$100 Copay IN; \$100 Copay OON Facility: \$150 Copay IN; \$150 Copay OON
Emergent/Non-Emergent: \$270 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$315 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$225 IN Non-Emergent: 30% Coinsurance OON
\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.	\$0 Copay IN; 30% Coinsurance OON. Up to 24 One-way trips. Trip limit waived if trip is part of continued acute care after discharge from ER.
\$125 Copay	\$125 Copay	\$125 Copay
\$35 Copay	\$35 Copay	\$5 Copay
\$375/admit IN; \$500/admit OON	\$325/admit IN; \$500/admit OON	\$150/day (days 1-7) IN, \$0/day (days 8-90) IN; \$150/day (days 1-7), \$0/day (days 8-90) OON
\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$150/day (days 1 – 7), \$0/day (days 8 – 90) IN;
\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON \$0/day (days 1 – 20); \$214/day (days 21 – 100) IN;	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON \$0/day (days 1 – 20); \$214/day (days 21 – 100) IN;	\$150/day (days 1 – 7), \$0/day (days 8 – 90) OON \$0/day (days 1 – 20); \$214/day (days 21 – 100) IN;
30% Coinsurance OON	30% Coinsurance OON	30% Coinsurance OON
\$0 Copay IN; 30% Coinsurance OON	\$0 Copay IN; 30% Coinsurance OON	\$0 Copay IN; 30% Coinsurance OON
sensors and transmitters dispensed via retail or mail order	order pharmacy limited to Abbott and LifeScan, all other brands are pharmacy are limited to Abbott and Dexcom, 20% coinsurance for al	other covered diabetic supplies IN; 30% Coinsurance OON
20% Coinsurance IN; 30% Coinsurance OON North: \$75 Allowance Once Per Quarter	20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON
South: \$95 Allowance Once Per Quarter	\$75 Allowance Once Per Quarter	N/A
N/A 28 Meals/14 Days IN/OON upon disc	N/A harge from an inpatient hospital stay, inpatient hospital psychiatric st	N/A av. or SNF stay to the home to gualify
	abetes. Members can see an endocrinologist and receive a glucomet	
	gital tools, coaching, in-person and virtual clinical support to help me	
	lure to manage condition through an app. Members will receive help sons on symptom monitoring, and regular mental health assessments	
	32 credits per month; no rollover of credits	4.11
0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	Services covered with applicable Copay listed for outpatient 0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON up to a maximum of a \$35 copay for a one month supply of insulin IN	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON -\$35 Coppay OON
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
	\$0 Copay IN; \$50 Copay OON (One every year)	
	d in full. IN/OON: A \$150 benefit maximum applies to non-standard lenses. \$200 benefit maximum for post cataract eyewear.	Standard Eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$225 benefit maximum applies to non-standard frames and a \$225 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$25 Copay OON (One every year)	\$0 Copay IN; \$0 Copay OON (One every year)	\$0 Copay IN; \$35 Copay OON (One every year)
2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	2 Hearing Aids Every year; TruHearing Advanced — \$399 copay; TruHearing Premium — \$699 copay IN; \$500 allowance IN/OON for any other hearing aid
Office Visit: \$0 Copay IN; 30% Coinsurance OON (One every X-ray: \$0 Copay IN; 30% Coins	six months) Includes exam, cleaning and flouride treatment urrance OON (One every year)	Office Visit: \$15 Copay IN; 30% Coinsurance OON (1 Every Six Months) Includes exam and cleaning X-ray: \$15 Copay IN; 30% Coinsurance OON (1 Every Year)
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
Combined maximum allowance of \$2,500	Combined maximum allowance of \$3500	N/A
Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 10% Coinsurance IN. Adjunct general services: Palliative 0%, all others 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, Adjunct general services: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Adjunctive General Services (Palliative Only): 0% Coinsurance IN. Palliative Only: 30% Coinsurance OON. See EOC for benefit limits.
\$15 Copay IN; \$30 OON	\$20 Copay IN; \$30 OON	\$15 Copay IN; \$15 OON
\$15 Copay IN; \$30 OON (eight visits)	\$20 Copay IN; \$30 OON (eight visits)	\$15 Copay IN; \$15 OON (eight visits)
\$20 Congress No. \$25 Communication CON	¢0 Cangu IN, ¢0 C OON	COE INICOS COM
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 IN; \$35 OON
\$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits)	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits)	\$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits)

Continued on next page

Freedom Blue PPO — WV (Products and pricing by county), cont.

	MERIT	SIGNATURE
	PART D DRUGS	
Formulary	Lean (Per	formance)
Deductible	Tier 1 - Tier 2: \$0, Tier 3 - Tier 5: \$590	\$0
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$10, Tier 3: 21%, Tier 4: 21%, Tier 5: 25% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: 21%, Tier 4: 21%, Tier 5: 25%	Preferred Retail: Tier 1: S0, Tier 2: S5, Tier 3: 25%, Tier 4: 46%, Tier 5: 33% Standard Retail: Tier 1: S7, Tier 2: S20, Tier 3: 25%, Tier 4: 46%, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2: \$10, Tier 3: 21%, Tier 4: 21%, Tier 5: 25% Standard Mail Order: Tier 1: \$21, Tier 2: \$60, Tier 3: 21%, Tier 4: 21%, Tier 5: 25%	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 46%, Tier 5: 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$60, Tier 3: 25%, Tier 4: 46%, Tier 5: 33%
OOP Threshold	\$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.	
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

DISTINCT	PRESTIGE	STANDARD
	PART D DRUGS	
	Lean (Performance)	
\$0	\$0	\$0
Preferred Retail: Tier 1: \$0, Tier 2: \$0,	Preferred Retail: Tier 1: \$0, Tier 2: \$0,	Preferred Retail: Tier 1: \$0, Tier 2: \$11,
Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: \$45, Tier 4: \$100, Tier 5: 33%
Standard Retail: Tier 1: \$7, Tier 2: \$15,	Standard Retail: Tier 1: \$7, Tier 2: \$15,	Standard Retail: Tier 1: \$5, Tier 2: \$19,
Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Preferred Mail Order: Tier 1: \$0, Tier 2: \$0,	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0,	Preferred Mail Order: Tier 1: \$0, Tier 2: \$27,
Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: \$115, Tier 4: \$275, Tier 5: 33%
Standard Mail Order: Tier 1: \$21, Tier 2: \$45,	Standard Mail Order: Tier 1: \$21, Tier 2: \$45,	Standard Mail Order: Tier 1: \$15, Tier 2: \$57,
Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Tier 3: \$141, Tier 4: \$300, Tier 5: 33%
\$2,0	000. Once that is met, the plan pays the full cost for covered Part D dru	ugs.
	Tier 3 Insulin: \$35 for 31-day supply and \$105 for 90-day	
Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for	supply at a retail or mail order pharmacy	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for
90-day supply at a retail or mail order pharmacy	Tier 4 Insulin: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	90-day supply at a retail or mail order pharmacy

WV Growth Product Highlights

Freedom Blue PPO Merit

All WV counties

\$0 plan with high monthly Part B giveback for the most cost-conscious consumer or low utilizers that don't want red tape when they need quality care.

- \$0 PCP and lab IN
- \$1,000 dental allowance with low coinsurance
- \$0 Tier 1 drugs; no Tier 1 or 2 deductible

Freedom Blue PPO Signature

All WV counties

Fundamental \$0 plan that provides robust benefits, no deductible, and extras like dental, OTC, fitness and more.

- Same cost sharing for PCP or specialist, in- or out-of-network
- \$0 lab IN
- \$2,000 dental allowance with low coinsurance
- \$0 Tier 1 drugs

Freedom Blue PPO Distinct

All WV counties

Low-priced plan for members who prefer lower and more predictable out-of-pocket costs and enhanced supplemental allowances.

- \$0 PCP IN and OON
- \$0 lab IN
- Per stay inpatient hospital
- \$2,500 dental allowance with low coinsurance
- \$0 Tier 1 and 2 drugs

Freedom Blue PPO Prestige

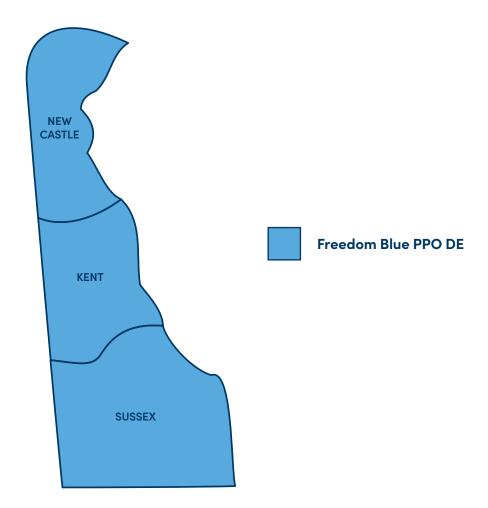
All WV counties

Mid-priced plan offers most generous medical and supplemental benefits with lowest out-of-pocket costs. Great for Medigap switchers looking for peace of mind for an affordable premium.

- \$0 PCP and specialist IN and OON
- \$0 Lab IN
- Per stay inpatient hospital
- First \$ dental with \$3,500 allowance and NO coinsurance IN
- \$0 Tier 1 and 2 drugs

All PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals

Freedom Blue PPO — DE



	SIGNATURE	NEW NAME! CHOICE DELUXE	PRESTIGE
Monthly Plan Premium	\$0	\$13	\$25
Part B Premium Buyback	\$2	\$1	\$0
Out-of-Pocket Maximum	Network: \$6,300; Combined: \$10,000	Network: \$6,000; Combined: \$9,550	Network: \$5,400; Combined: \$8,950
PCP Office Visit		\$0 Copay IN; \$0 Copay OON	
Specialist Office Visit	\$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON	\$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$50 copay OON	\$0 Copay IN; \$50 copay OON	\$0 Copay IN; \$40 copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$10 Copay IN; \$50 copay OON	\$10 Copay IN; \$50 copay OON	\$0 Copay IN; \$40 copay OON
X-rays	\$25 Copay IN; \$50 Copay OON	\$15 Copay IN; \$45 Copay OON	\$10 Copay IN; \$40 Copay OON
Radiation Therapy	400E 0 IVI 40E 0 00V	\$60 Copay IN; \$75 Copay OON	A450 0 111 A000 0 0011
Advanced Imaging	\$225 Copay IN; \$350 Copay OON	\$250 Copay IN; \$300 Copay OON	\$150 Copay IN; \$300 Copay OON
Preventive/Screening	\$25 C INL \$50 C OON	Covered in Full (Office visit copay may apply) IN/OON	\$0.CIN-\$40.COON
Outpatient Physical and Speech Therapy	\$25 Copay IN; \$50 Copay OON	\$25 Copay IN; \$50 Copay OON	\$0 Copay IN; \$40 Copay OON
Medicare Covered Acupuncture	\$25 Copay IN; \$50 Copay OON \$30 Copay IN; \$50 Copay OON	\$25 Copay IN; \$50 Copay OON \$25 Copay IN; \$50 Copay OON	\$0 Copay IN; \$40 Copay OON \$30 Copay IN; \$40 Copay OON
Outpatient Occupational Therapy Outpatient Mental Health	\$40 Copay IN; \$50 Copay OON	\$30 Copay IN; \$45 Copay OON	\$30 Copay IN; \$40 Copay OON \$30 Copay IN; \$40 Copay OON
Outpatient Substance Abuse	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON	\$30 Copay IN; \$40 Copay OON
Outpatient Surgical	ASC: \$225 Copay IN; \$350 Copay OON	ASC: \$250 Copay IN; \$300 Copay OON	ASC: \$155 Copay IN; \$300 Copay OON
outputient surgicul	Facility: \$300 Copay IN; \$350 Copay OON	Facility: \$350 Copay IN; \$400 Copay OON	Facility: \$200 Copay IN; \$300 Copay OON
Ambulance	Emergent/Non-Emergent: \$225 IN;	Emergent/Non-Emergent: \$250 IN;	Emergent/Non-Emergent: \$250 IN;
	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
Transportation		N/A	3
Emergency Room	\$125 Copay	\$125 Copay	\$110 Copay
Urgent Care	\$40 Copay	\$50 Copay	\$0 Copay
Inpatient Hospital Stay	\$220/day (days 1 – 5), \$0/day (days 6 – 90) IN;		
(COVID-19 cost share waiver has been removed)	\$350/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$425/Stay IN; \$350/day (days 1 – 5), \$0/day (days 6 – 90) OON	\$325/admit IN; \$395/admit OON
Inpatient Psychiatry Stay	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;	\$425/day (days 1 – 3), \$0/day (days 4 – 90) IN;
	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$500/day (days 1 – 3), \$0/day (days 4 – 90) OON
Skilled Nursing Facility	\$0	0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OC	DN
Home Health		\$0 Copay IN; 30% Coinsurance OON	
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail of	order pharmacy limited to Abbott and LifeScan, all other brands are	e covered through a DME Supplier; continuous glucose monitors,
B 11 44 B 15 1	sensors and transmitters dispensed via retail or mail order	pharmacy are limited to Abbott and Dexcom, 20% coinsurance for c	all other covered diabetic supplies IN; 30% Coinsurance OON
Durable Medical Equipment	Avec All O D O	20% Coinsurance IN; 30% Coinsurance OON	**************************************
OTC .	\$190 Allowance Once Per Quarter	N/A	\$100 Allowance Once Per Quarter
Flex Card	N/A	Dental/Vision/Hearing, OTC — \$630 limit, Part B — \$200 (\$50 limit per transaction)	N/A
Meal Benefit		Part B — \$200 (\$50 limit per transaction)	28 Meals/14 Days IN/OON upon discharge from
Medi bellelli	N/A	N/A	an inpatient hospital stay, inpatient hospital psychiatric stay, or SNF stay to the home to qualify
Onduo	\$0 Ondug Virtual Diabetes Program for Dia	ı ıbetes. Members can see an endocrinologist and receive a glucome	
Spring Health		ital tools, coaching, in-person and virtual clinical support to help m	
CHF and COPD Management powered by Vida		ure to manage condition through an app. Members will receive help	
on and our printing of the post of the pos		ons on symptom monitoring, and regular mental health assessmen	
Fitness Benefit		32 credits per month; no rollover of credits	
Additional Telehealth Services		Services covered with applicable Copay listed for outpatient	
Part B Drugs — Chemotherapy and All Other Part B	0% 19 99% Coincurance for	Part B rebatable drugs and 20% Coinsurance for all other Part B dru	igs IN: 30% Coinsurance OON
rai i b brags — Chemomerapy and All Other Part b	0% - 19.33% Comsurance for 1		
Part B Drugs — Cnemotherapy and All Other Part B Part B Drugs — Insulin		up to a maximum of a \$35 copay for a one month supply of insulin II	
		up to a maximum of a \$35 copay for a one month supply of insulin II \$30 Copay IN; \$30 Copay OON	
Part B Drugs — Insulin	20% Coinsurance		N; \$35 Copay OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit)	20% Coinsurance t \$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standar	y; \$35 Copay OON \$0 Copay IN; \$0 Copay OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear)	20% Coinsurance (\$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covere	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standars \$200 benefit maximum for post cataract eyewear.	\$0 Copay N; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lenses
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit)	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON	N; \$35 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lenses \$0 Copay IN; \$0 Copay OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam	20% Coinsurance (\$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covere \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay OON (One every year)	Si Copay OON Si Copay IN; Si Copay OON d frames and a \$150 benefit maximum for specialty contact lenses Si Copay IN; Si Copay OON Si Copay IN; Si Copay OON (One every year)
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay; Its; \$500 allowance IN/OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standars \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lenses \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; Trulearing Advanced — \$699 copay; Trulearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	State of the state
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; Trulearing Advanced — \$699 copay; Trulearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standars \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 allowance IN/OON for any other hearing aid 0% Coinsurance OON (One every six months) Includes exam, cleani	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TrulHearing Advanced — \$699 copay TrulHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids)	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 3	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; Trulearing Advanced — \$699 copay; Trulearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON 2 Hearing Aids Every year; TruHearing Advanced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 allowance IN/OON for any other hearing aid X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year)	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ng, and fluoride treatment
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 Copa	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 330 Copay OON Combined maximum allowance of \$2500	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 3 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive	\$35 Copay OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay; IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN. 50%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In In/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON 2 Hearing Aids Every year; TruHearing Advanced – \$699 copay; TruHearing Premium – \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Or, Palliative-40% All Others IN, 50%	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative—40% All Others IN
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	20% Coinsurance (\$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covere \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay; IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 3 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Perisdontics, Porsthadontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative ~40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON 2 Hearing Aids Every year; TruHearing Advanced - \$699 copay; TruHearing Premium - \$999 copay IN; \$500 allowance IN/OON for any other hearing aid 0% Coinsurance OON (One every six months) Includes exam, cleani X-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Porsidontics, Porsidontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500	Sy \$35 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Enddoorlics, Periodontics, Porsthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Polliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay; IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN. 50%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sid in full, III/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits.	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctives \$0 Capay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctives \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Orallotive - 40% All Others IN 50% Palliative - 40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See EOC for benefit limits.
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Ois Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% S15 Copay IN; \$30 OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard standard s	Signification (Signification of Signification of Signific
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium - \$999 copay; IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative -40% All Others IN. 50% Palliative -40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) ed in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced - \$699 copay; TruHearing Premium - \$999 copay IN; \$500 allowance IN/OON for any other hearing aid 0% Coinsurance OON (One every six months) Includes exam, cleani X-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Persidontics, Prosthadontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative - 40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 COpay OON \$10 Copay IN; \$15 COpay OON	Signature Sign
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Ois Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% S15 Copay IN; \$30 OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard standard s	Signature of the statement of the statem
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cordiac and Pulmonary Rehab and SET,	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sid in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON	SO Copay IN; SO Copay OON d frames and a \$150 benefit maximum for specialty contact lenses \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services: See EOC for benefit limits. \$0 Copay IN; \$0 OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cordiac and Pulmonary Rehab and SET,	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray: \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance OON (One every year) Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON	SO Copay IN; SO Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services: See EOC for benefit limits. \$0 Copay IN; \$0 OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cordiac and Pulmonary Rehab and SET,	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani x-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others ON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 ON (eight visits) \$30 Copay IN; \$30 ON (eight visits) \$30 Copay IN; \$30 ON (10 visits) \$0 Copay IN; \$30 ON (10 visits)	SO Copay IN; SO Copay OON d frames and a \$150 benefit maximum for specialty contact lense: \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services: See EOC for benefit limits. \$0 Copay IN; \$0 OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; 30% Coinsurance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 Oon (eight visits) \$30 Copay IN; \$30 Oon (eight visits) \$30 Copay IN; \$30 Oon (10 visits) \$0 Copay IN; 30% Coinsurance OON DRUGS	SO Copay IN; SO Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON \$0 Copay IN; SO Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See EOC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 Copay OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Ox Palliative -40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 OON (10 visits)	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; 330 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: \$0? Pallicitive-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 OON (eight visits) \$30 Copay IN; \$30 Copay OON	Signature of the state of the s
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Pallicative-40% All Others IN, 50% Pallicative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5,	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; Truthearing Advanced - \$699 copay; Truthearing Premium - \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray; \$0 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Porsidontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others ON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 CON (eight visits) \$30 Copay IN; \$30 CON (10 visits) \$0 Copay IN; \$30 CON (10 visits) \$0 Copay IN; 30% Coinsurance OON DRUGS Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$5,	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See ECC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 OON (10 visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0,
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Of: Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% Palliative-40% All Others IN. 50% S15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 3: 25%, Tier 3: 25%, Tier 4: 44%, Tier 5: 33%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; 330 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: \$0? Pallicitive-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 OON (eight visits) \$30 Copay IN; \$30 Copay OON	Signary OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ing, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See EOC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 COPay IN
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Pallicative-40% All Others IN, 50% Pallicative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5,	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) Ind in full. IN/OON: A \$150 benefit maximum applies to non-standard standard standa	\$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See ECC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 OON (10 visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0,
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Ox Pallicitive -40% All Others IN. 50% Palliative -40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15,	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) sd in full. IN/OON: A \$150 benefit maximum applies to non-standard for full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: Or, Pallicitive-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 Copay ON In For 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%, Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%, Preferred Mail: Tier 1: \$0, Tier 2: \$0,	Signature of the state of the s
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty Tier	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Preferred Mait: Tier 1: \$0, Tier 2: \$15, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Preferred Mait: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 44%, Tier 5: 33%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; Truthearing Advanced - \$699 copay; Truthearing Premium - \$999 copay IN; \$500 allowance IN/OON for any other hearing aid % Coinsurance OON (One every six months) Includes exam, cleani X-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Porstohadontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON.Adjunctive General Services: 0% Palliative-40% All Others IN. 50% Palliative-40% All Others OON. There is a maximum of \$2500 Allowance IN/OON for all services. See EOC for benefit limits. \$10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 CON (eight visits) \$30 Copay IN; \$30 Consurance OON DRUGS Lean (Performance) Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	N; \$35 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliatrive-40% All Others IN 50% Palliatrive-40% All Others OON. There is a maximum of \$35C Allowance IN/OON for all services. See EOC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 OON (10 visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Office Visit: \$0 Copay IN; 30 \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN. 50% S15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$45, Tier 3: 25%, Tier 4: 44%, Tier 5: 33%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) Ind in full. IN/OON: A \$150 benefit maximum applies to non-standard standard standa	N; \$35 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (one every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Polliative – 40% All Others IN 50% Palliative – 40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See EOC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 OON (10 visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$2, Tier 2: \$45,
Part B Drugs — Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Formulary Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	20% Coinsurance of \$30 Copay IN; \$30 Copay OON Standard Eyeglass lenses and frames or contact lenses are covered \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2000 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON, Adjunctive General Services: 0% Pallicative -40% All Others IN, 50% Pallicative-40% All Others OON. There is a maximum of \$2000 Allowance IN/OON for all services. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$30 Copay IN; \$30 OON (10 visits) PART D Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 44%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 44%, Tier 5: 33%	\$30 Copay IN; \$30 Copay OON \$0 Copay IN; \$50 Copay OON (One every year) In full. IN/OON: A \$150 benefit maximum applies to non-standard for full. IN/OON: A \$150 benefit maximum applies to non-standard \$200 benefit maximum for post cataract eyewear. \$30 Copay IN; \$30 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid Coinsurance OON (One every six months) Includes exam, cleant X-ray; \$0 Copay IN; 30% Coinsurance OON (One every year) \$30 Copay IN; \$30 Copay OON Combined maximum allowance of \$2500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery; 40% Coinsurance IN/OON, Adjunctive General Services: 0% Palliative-40% All Others IN, 50% S10 Copay IN; \$15 Copay OON \$10 Copay IN; \$15 Copay OON \$30 Copay IN; \$30 Copay IN; \$30 Copay OON \$30 Copay IN; \$30	N; \$35 Copay OON \$0 Copay IN; \$0 Copay OON d frames and a \$150 benefit maximum for specialty contact lense \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (One every year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay TruHearing Premium — \$999 copay IN; \$500 allowance IN/OOI for any other hearing aid ng, and fluoride treatment \$0 Copay IN; \$0 Copay OON Combined maximum allowance of \$3500 Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 50% Palliative-40% All Others OON. There is a maximum of \$350 Allowance IN/OON for all services. See EOC for benefit limits. \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (eight visits) \$0 Copay IN; \$0 OON \$0 Copay IN; \$0 OON (10 visits) Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
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PRODUCTS AND PRICING BY COUNTY | MEDICARE ADVANTAGE

Freedom Blue PPO – DE (Products and pricing by county)

DE Growth Product Highlights

Freedom Blue PPO Signature

All DE Counties

\$0 plan with robust benefits, no deductible, and extras like dental, OTC, fitness and more.

- Same cost sharing for PCP or specialist, in- or out-of-network
- \$0 lab IN
- \$2,000 dental allowance
- \$0 Tier 1 drugs

REDESIGNED

Freedom Blue PPO Choice Deluxe

All DE Counties

Formerly Freedom Blue PPO Distinct

Low-priced plan with strong core medical benefits and a flex card that allows members to determine how to spend their healthcare dollars.

- \$0 PCP IN and OON
- \$630 Flex Card for use with dental, vision, or hearing costs and/or OTC items
- Additional \$200 Flex allowance for most Part B outpatient copays
- \$2,500 dental allowance
- \$0 Tier 1 drugs

Freedom Blue PPO Prestige

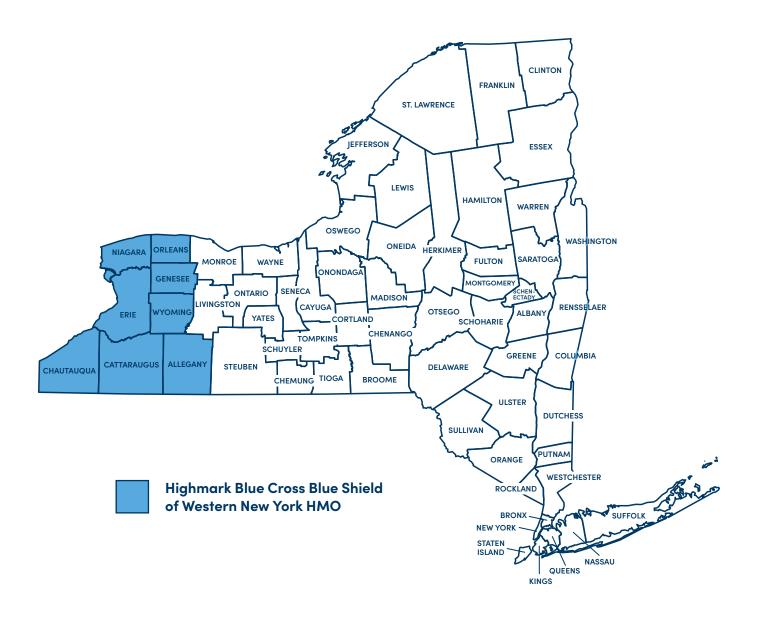
All DE Counties

Mid-priced plan offers most generous medical and supplemental benefits with the lowest out-of-pocket costs. Great for Medigap switchers and consumers looking for peace of mind for an affordable premium.

- \$0 PCP and specialist IN and OON
- \$0 lab and PT IN
- \$0 urgent care
- \$3,500 dental allowance
- \$0 Tier 1 and 2 drugs

All PPO Plans include in-network access to Bayhealth and ChristianaCare as well as BlueCard access to BCBSA's national network of doctors and hospitals

Highmark Blue Cross Blue Shield of Western New York HMO



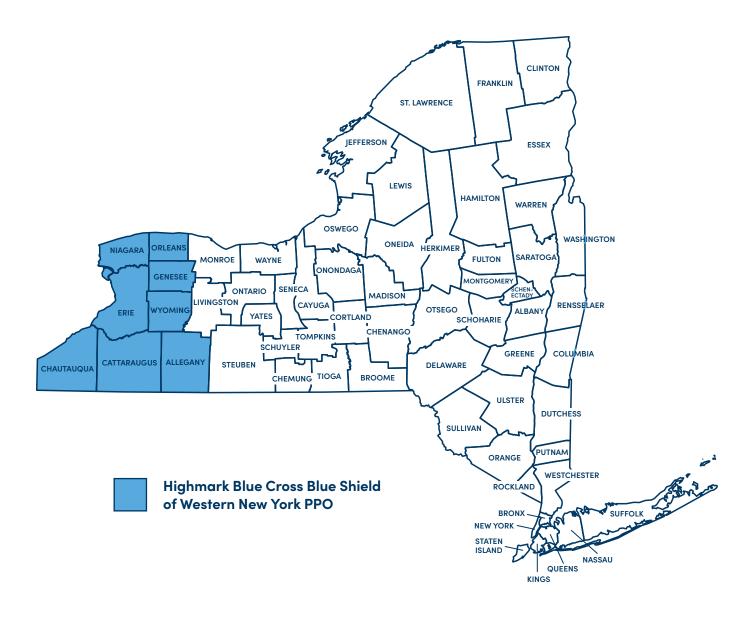
^{*}Pricing is subject to CMS approval

Highmark Blue Cross Blue Shield of Western New York HMO (Products and pricing by county)

	SENIOR BLUE BASIC HMO	BLUESAVER HMO
Monthly Plan Premium	\$0	\$0
Part B Premium Buyback	\$71	\$4
Out-of-Pocket Maximum	Network: \$8,300; Combined: N/A	Network: \$6,900; Combined: N/A
PCP Office Visit	\$0 - \$10 Copay IN	\$0 Copay IN
Specialist Office Visit	\$50 Copay IN	\$30 Copay IN
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$10 Lab Copay IN; \$60 Diagnostic test IN	\$0 Lab Copay IN; \$50 Diagnostic test IN
Lab and Diagnostic Tests (Outpatient Facility)	\$10 Lab Copay IN; \$60 Diagnostic test IN	\$0 Lab Copay IN; \$50 Diagnostic test IN
X-rays	\$50 Copay IN	\$45 Copay IN
Radiation Therapy	20% Coinsurance IN	20% Coinsurance IN
Advanced Imaging	\$225 Copay IN	\$175 Copay IN
Preventive/Screening	\$0 Copay IN	\$0 Copay IN
Outpatient Physical and Speech Therapy	\$40 Copay IN	\$30 Copay IN
Medicare Covered Acupuncture Outpatient Occupational Therapy	\$50 Copay IN \$35 Copay IN	\$30 Copay IN
Outpatient Occupational Therapy Outpatient Mental Health	\$35 Copay IN \$40 Copay IN	\$30 Copay IN \$40 Copay IN
Outpatient Substance Abuse	\$40 Copay IN	\$40 Copay IN
Outpatient Surgical	ASC: \$425 Copay IN; Facility: \$475 Copay IN	ASC: \$275 Copay IN; Facility: \$375 Copay IN
Ambulance	\$275 Copay	\$270 Copay
Transportation		/A
Emergency Room	\$110 Copay	\$110 Copay
Urgent Care	\$45 Copay	\$45 Copay
Inpatient Hospital Stay		·
(COVID-19 cost share waiver has been removed)	\$375 per day for days 1 – 5, \$2,250 OOP Max per year	\$350 per day for days 1 – 5, \$2,100 OOP Max per year
Inpatient Psychiatry Stay	\$335 per day for days 1 – 4, \$2,010 OOP Max per year	\$395 per day for days 1 – 4, \$1,580 OOP Max per year
Skilled Nursing Facility	\$0 per day for days 1 – 20; \$214 per day for day	
Home Health		pay IN
Diabetic Supplies and Services	\$0 Co	
	Continuous alucase manitors sensors and transmitters dispensed via n	etail or mail order pharmacy are limited to LifeScan® and Roche®. ria retail or mail order pharmacy are limited to Abbott and Dexcom.
	All other desired brands will need to be obtained from a Durable	
Durable Medical Equipment		c shoes/inserts; 20% all other items
отс	N/A	\$140 quarterly allowance
Flex Card	N/A	N/A
Meal Benefit	\$0 for one meal per day for seven days upon discharge fr	om an inpatient hospital, SNF or Inpatient Psychiatry stay.
	Must be activated with	
Onduo	\$0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited s	ers can see an endocrinologist and receive a glucometer
Spring Health	\$0 behavioral health care program with digital tools, o	
	members address bel	
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage co	ndition through an app. Members will receive help from dietitians,
F1	health coaches, in-app trackers, lessons on symptom	
Fitness Benefit Additional Telehealth Services		no rollover of credits
Part B Drugs — Chemotherapy and All Other Part B	Services covered with applica	s and 20% Coinsurance for all other Part B drugs IN
Part B Drugs — Chemotherapy and All Other Part B Part B Drugs — Insulin		s and 20% Coinsurance for all other Part B arugs IN 35 copay for a one month supply of insulin
Medicare Covered Vision (Office Visit)	\$50 (except \$0 for diabetic retinal eye exam)	\$30 (except \$0 for diabetic retinal eye exam)
Routine Vision (Office Visit)	\$25 Copay IN (One every year)	\$25 Copay IN (One every year)
Routine Vision (Eyewear)	N/A	\$100 Allowance for routine eyewear
Medicare Covered Hearing Exam	\$50 Copay IN	\$30 Copay IN
Routine Hearing Exam	N/A	\$45 Copay IN (One every year)
Routine Hearing (Hearing Aids)	N/A	Two Hearing Aids every year; TruHearing Advanced — \$699 copay
		TruHearing Premium — \$999 copay
Routine Dental	Office: \$20 Copay IN; (One every six months) Includes exam, cleaning and flouride treatment; X_ray: \$20 Copay IN (One every	Office: \$0 Copay IN; (One every six months) Includes exam, cleaning and flouride treatment; X-ray: \$0 Copay IN (One every
Madiana Carrand Carrandania B. 1.1	year)	year)
Medicare Covered Comprehensive Dental Dental Allowance — Preventive and/or Comprehensive	\$50 Copay IN Combined maximum allowance of \$1000	\$30 Copay IN Combined maximum allowance of \$2000
Comprehensive Dental — Supplemental	Combined maximum allowance of \$1000	Restorative Services: medicament application 0%, all others:
Comprehensive Demai — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/	50% Coinsurance.Endodontics, Prosthodontics (removable and
	Maxillofacial Surgery, Extractions, Non-Routine Services,	fixed), Oral/Maxillofacial Surgery: 50% . Periodontal cleanings/
	Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal	maintenance \$0 Copay, all other periodontal services: 50%
	cleanings \$20 Copay IN. See EOC for benefit limits.	Coinsurance. Adjunct general services: 0% palliative, all others: 50% Coinsurance. See EOC for benefit limits.
Medicare Covered Chiropractic	\$15 Co	
Routine Chiropractic	\$15 Copay IN (three per plan year)	\$15 Copay IN (six per plan year)
Medicare Covered Podiatry	\$50 Copay IN	\$30 Copay IN
Routine Podiatry	\$50 Copay IN (three visits)	\$30 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital,	Cardiac Rehab: \$10 Copay IN	Cardiac Rehab: \$10 Copay IN
Outpatient Blood	Partial Hospital: \$55 Copay IN	Partial Hospital: \$55 Copay IN
···	Outpatient Blood: \$0 Copay IN	Outpatient Blood: \$0 Copay IN
···	Outpatient Blood: \$0 Copay IN N/A	
Combined Acupuncture and Massage Therapy Allowance	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS	Outpatient Blood: \$0 Copay IN N/A
Combined Acupuncture and Massage Therapy Allowance Formulary	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental	Outpatien! Blood: \$0 Copay IN N/A Fundamental
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12,	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2,
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33%	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12,	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2,
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30,	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0,
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 330,	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 330, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$42.50,	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$1.50, Tier 2: \$42.50,
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$42,50, Tier 3: 25%, Tier 4: 33%, Tier 5: 33%	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$4, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%
Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$47, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$42.50, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% S2,000. Once that is met, the plan pays the full cost for	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% \$2,000. Once that is met, the plan pays the full cost for
Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) OOP Threshold IRA Benefits — T3 and T4	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$7, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$42, 50, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$15, 50, Tier 2: \$42, 50, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% \$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% \$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.
Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) OOP Threshold	Outpatient Blood: \$0 Copay IN N/A PART D DRUGS Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$17, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$47, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$30, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$42.50, Tier 3: 25%, Tier 4: 33%, Tier 5: 33% S2,000. Once that is met, the plan pays the full cost for	Outpatient Blood: \$0 Copay IN N/A Fundamental \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$2, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 5: 33% Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% \$2,000. Once that is met, the plan pays the full cost for

SENIOR BLUE 601 HMO	SENIOR BLUE SELECT HMO	SENIOR BLUE 651 HMO
\$0	\$40	\$101
\$1	\$40	\$101
Network: \$6,700; Combined: N/A	Network: \$6,700; Combined: N/A	Network: \$6,700; Combined: N/A
\$0 -\$5 Copay IN	\$0 Copay IN	\$0 Copay IN
\$45 Copay IN	\$30 Copay IN	\$25 Copay IN
\$0 Lab Copay IN; \$45 Diagnostic test IN	\$0 Lab Copay IN; \$50 Diagnostic test IN	\$5 Lab Copay IN; \$40 Diagnostic test IN
\$0 Lab Copay IN; \$45 Diagnostic test IN	\$0 Lab Copay IN; \$50 Diagnostic test IN	\$5 Lab Copay IN; \$40 Diagnostic test IN
\$45 Copay IN	\$45 Copay IN	\$40 Copay IN
20% Coinsurance IN	20% Coinsurance IN	20% Coinsurance IN
\$150 Copay IN \$0 Copay IN	\$175 Copay IN \$0 Copay IN	\$150 Copay IN \$0 Copay IN
\$15 Copay IN	\$25 Copay IN	\$15 Copay IN
\$45 Copay IN	\$30 Copay IN	\$25 Copay IN
\$15 Copay IN	\$25 Copay IN	\$15 Copay IN
\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
ASC: \$225 Copay IN; Facility: \$325 Copay IN	ASC: \$300 Copay IN; Facility: \$400 Copay IN	ASC: \$225 Copay IN; Facility: \$325 Copay IN
\$200 Copay	\$300 Copay	\$200 Copay
	N/A	
\$125 Copay	\$125 Copay	\$125 Copay
\$55 Copay	\$55 Copay	\$55 Copay
\$290 per day for days 1-7, \$2,030 OOP Max per year	\$335 per day for days 1-5, \$1,675 OOP Max per year	\$225 per day for days 1-7, \$1,575 OOP Max per year
	1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
\$260 per day for days 1-6, \$1,560 OOP Max per year	\$260 per day for days 1-6, \$1,560 OOP Max per year	\$215 per day for days 1-6, \$1,290 OOP Max per year
\$0 per day	for days 1 – 20; \$214 per day for days 21 – 100. No yearly benefit period \$0 Copay IN	maximum.
	•	
retail or mail order pharmacy are limited to Abbott and Dexco	\$0 Copay IN etail or mail order pharmacy are limited to LifeScan® and Roche®. Cor m. All other desired brands will need to be obtained from a Durable N	
	\$0 compression stockings, diabetic shoes/inserts; 20% all other items	
\$25 quarterly allowance	\$70 quarterly allowance	\$60 quarterly allowance
N/A	N/A	N/A
\$0 for one meal per day for seven days upon d	lischarge from an inpatient hospital, SNF or Inpatient Psychiatry stay.	Must be activated within 30 days of discharge.
\$0 Onduo Virtual Diabetes Program for [Diabetes. Members can see an endocrinologist and receive a glucome	eter with an unlimited supply of test strips
\$0 behavioral health care program with a	ligital tools, coaching, in-person and virtual clinical support to help m	embers address behavioral health needs.
\$0 program for COPD and Congestive Heart Fai	ilure to manage condition through an app. Members will receive help	from dietitians, health coaches, in-app trackers,
	ssons on symptom monitoring, and regular mental health assessment	
	32 credits per month; no rollover of credits	
	Services covered with applicable Copay listed for outpatient	
	nsurance for Part B rebatable drugs and 20% Coinsurance for all other	
	pinsurance up to a maximum of a \$35 copay for a one month supply of	
\$45 (except \$0 for diabetic retinal eye exam)	\$30 (except \$0 for diabetic retinal eye exam)	\$25 (except \$0 for diabetic retinal eye exam)
\$0 Copay IN (One every year)	\$25 Copay IN (One every year)	\$25 Copay IN (One every year)
\$100 Allowance for routine eyewear \$45 Copay IN	\$200 Allowance for routine eyewear \$30 Copay IN	\$200 Allowance for routine eyewear \$25 Copay IN
\$45 Copay IN (One every year)	\$45 Copay IN (One every year)	\$45 Copay IN (One every year)
Two Hearing Aids every year; TruHearing Advanced — \$599 copay;		Two Hearing Aids every year; TruHearing Advanced — \$499 copay;
TruHearing Premium — \$899 copay	TruHearing Premium — \$799 copay	TruHearing Premium — \$799 copay
Office: \$0 Copay IN (One every six months) Includes exam and	Office: \$0 Copay IN (One every six months) Includes exam and	Office: \$0 Copay IN (One every six months) Includes exam and
cleaning	cleaning	cleaning
X-ray: \$0 Copay IN (One every year)	X-ray: \$0 Copay IN (One every year)	X-ray: \$0 Copay IN (One every year)
\$45 Copay IN	\$30 Copay IN	\$25 Copay IN
Comprehensive maximum allowance of \$2000	Comprehensive maximum allowance of \$2000	Comprehensive maximum allowance of \$2000
Restorative Services, Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance. Periodontal cleanings/maintenance: 50 Copay, Adjunct general services (Palliative only): 50% Coinsurance. See EOC for benefit limits.	Restorative Services, Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance. Periodontal cleanings/maintenance: \$0 Copay, all other periodontal services: 50% Coinsurance. Adjunct general services (Palliative only): 50% Coinsurance. See EOC for benefit limits.	Restorative Services, Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance. Periodontal cleanings/maintenance: \$0 Copay, all other periodontal services: 50% Coinsurance. Adjunct general services (Palliative only): 50% Coinsurance. See EOC for benefit limits.
¢1E ConguIN (siml)	\$15 Copay IN	\$15 Congy IN (12 I
\$15 Copay IN (six per plan year)	\$15 Copay IN (12 per plan year) \$30 Copay IN	\$15 Copay IN (12 per plan year)
\$45 Copay IN \$45 Copay IN (three visits)	\$30 Copay IN \$30 Copay IN (three visits)	\$25 Copay IN \$25 Copay IN (three visits)
Cardiac Rehab: \$15 Copay IN	Cardiac Rehab: \$15 Copay IN	Cardiac Rehab: \$15 Copay IN
Partial Hospital: \$55 Copay IN	Partial Hospital: \$55 Copay IN	Partial Hospital: \$55 Copay IN
Outpatient Blood: \$0 Copay IN	Outpatient Blood: \$0 Copay IN	Outpatient Blood: \$0 Copay IN
N/A	N/A	N/A
	PART D DRUGS	
N/A	Fundamental	Fundamental
N/A	\$0	\$0
N/A	Preferred Retail: Tier 1: \$0, Tier 2: \$10, Tier 3: 25%, Tier 4: 40%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 40%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
N/A	Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: 25%, Tier 4: 40%, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$37.50,	Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$37.50,
N/A	Tier 3: 25%, Tier 4: 40%, Tier 5: 33%	Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33%
N/A	\$2,000. Once that has been met, the plan pays the full cost for covered Part D drugs.	Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33% \$2,000. Once that has been met, the plan pays the full cost for covered Part D drugs.

Highmark Blue Cross Blue Shield of Western New York PPO



^{*}Pricing is subject to CMS approval

Highmark Blue Cross Blue Shield of Western New York PPO (Products and pricing by county)

Marchy Phresion 150		FREEDOM NATION PPO	NEW! FREEDOM NATION PRESTIGE PPO
Out-off-Prefect Nations	Monthly Plan Premium	\$30	\$52
FEO Prilites Vanish FEO Prili			
Special of Dispute No. Proceedings Special of Dispute No. Procedure Special of Dispute No. Procedure Special of Dispute No. Procedure Special of Dispute No. Procedure No.			
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inpotential hospital Story (CDVC) 1.15 scot a hear walver has been removed) (EDVC) 1.15 scot a hear walver has been removed) (EDVC) 1.15 scot a hear walver has been removed) (EDVC) 1.15 scot a hear walver has been removed) (EDVC) 1.15 scot a hear walver has been removed) (EDVC) 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear walver has been removed by Story 1.15 scot a hear was walver a been been been depended by Story 1.15 scot a hear was walver a been been been removed by Story 1.15 scot a hear was walver a been been been removed by Story 1.15 scot a hear was walver a been been been depended by Story 1.15 scot a hear was walver a been been been been seen and been removed by Story 1.15 scot a hear was walver a been been depended by Story 1.15 scot a hear was walver a been been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a been been seen and been removed by Story 1.15 scot a hear was walver a hear was walver was walver was walver was walver a hear was walver walver was walver wal			
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Behefith period maximum IN, 50% Consurance CON No yearly benefit period maximum IN, 50% Consurance CON 100 behefit Supplies and Services 100 behefit Supplies 100 behefit S	Skilled Nursina Facility		
Bobbetic Supplies and Services Dichatts (public sources)			
Disbatic, plucometer, test strip, and lance thronds dispensed vis relation and order phormacy are limited to LifeScan* and Roberts* Continuous glaces months, sensers and forestraints* dispensed vis relation and order phomosy and large through glaces months, sensers and forestraints* dispensed vis relation and order phomosy and forther deviced brooks and the sensers and the sense through		\$0 Copay IN; 50% Coinsurance OON	\$0 Copay IN; 50% Coinsurance OON
Cominuous glucose monitors, sensors and transmitters dispensed via retail or mail order phormacy are limited of Abbott and Seption process.) Durable Medical Equipment 90 compression stockings, disbellic sheer, investigations (1998) provide for an exception process.) 180 quarterly allowance 180 quarterly allowance 180 quarterly allowance 180 for one meal per day for sean days upon fills how the main inputient hospital), SNF or impatient Psychiatry stoy. Media Benefit 80 for one meal per day for sean days upon fills how the main inputient hospital), SNF or impatient Psychiatry stoy. Must be sectived within 30 per circled within 30 per section of the stop of the street process. Spring Health 80 for one meal per day for sean days upon fills how the main impatient hospital), SNF or impatient Psychiatry stoy. Must be sectived within 30 per section of the street process of the street process. Spring Health 80 behavioral health core program with digital tools, couching, in-person with	Diabetic Supplies and Services		
All other desired broads will need to be obtained from a Durbele Medicare Equipment (DME) provider for an exception process). Durchle Medical Equipment 1 90 compared to the Section of th			
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mail order pharmacy			

FOREVER BLUE VALUE PPO	FOREVER BLUE 751 PPO
\$131	\$197
\$0	\$0
Network: \$6,700; Catastrophic: \$10,000 \$0 – \$10 Copay IN; 35% Coinsurance OON	Network: \$6,700 Catastrophic: \$10,000 \$0 – \$5 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
\$5 Lab Copay IN; \$45 Diagnostic Tests; Both 35% Coinsurance OON	\$5 Lab Copay IN; \$40 Diagnostic Tests; Both 25% Coinsurance OON
\$5 Lab Copay IN; \$45 Diagnostic Tests; Both 35% Coinsurance OON	\$5 Lab Copay IN; \$40 Diagnostic Tests; Both 25% Coinsurance OON
\$45 Copay IN; 35% Coinsurance OON 20% Coinsurance IN; 35% Coinsurance OON	\$40 Copay IN; 25% Coinsurance OON 20% Coinsurance IN; 25% Coinsurance OON
\$150 Copay IN; 35% Coinsurance OON	\$150 Copay IN; 25% Coinsurance OON
\$0 Copay IN; 35% Coinsurance OON	\$0 Copay IN; 25% Coinsurance OON
\$20 Copay IN; 35% Coinsurance OON	\$20 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON \$20 Copay IN; 25% Coinsurance OON
\$20 Copay IN; 35% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON	\$20 Copay IN; 25% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 50% Coinsurance OON
ASC: \$250 Copay IN; 35% Coinsurance OON	ASC: \$200 Copay IN; 25% Coinsurance OON
Facility: \$350 Copay IN; 35% Coinsurance OON	Facility: \$300 Copay IN; 25% Coinsurance OON
\$250 Copay	\$225 Copay /A
	Copay
\$55.0	Copay
\$295 per day for days 1 – 7, \$2,065 OOP Max per year IN; 35% Coinsurance OON	\$205 per day for days 1 – 7, \$1,435 OOP Max per year IN; 30% Coinsurance OON
\$270 per day for days 1 – 6, \$1,620 OOP Max per year IN; 35% Coinsurance OON	\$270 per day for days 1 – 6, \$1,620 OOP Max per year IN; 30% Coinsurance OON
\$0 per day for days 1 – 20; \$214 per day for days 21 – 100, No yearly benefit period maximum IN;	\$0 per day for days 1 – 20; \$214 per day for days 21 – 100, No yearly benefit period maximum IN;
35% Coinsurance OON \$0 Copay IN; 35% Coinsurance OON	30% Coinsurance OON \$0 Copay IN; 25% Coinsurance OON
Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are via retail or mail order pharmacy are limited to Abbott and Dexcom. All other desired brands will n	pay IN limited to LifeScan® and Roche®. Continuous glucose monitors, sensors and transmitters dispensed eed to be obtained from a Durable Medicare Equipment (DME) provider (or an exception process.). urance OON
	ts; 20% all other items IN; 50% Coinsurance OON
\$60 quarterly allowance	\$60 quarterly allowance /A
\$0 for one meal per day for seven days upon discharge from an inpatient nospito	al, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.
\$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endo	ocrinologist and receive a glucometer with an unlimited supply of test strips IN
	d virtual clinical support to help members address behavioral health needs. IN
	an app. Members will receive help from dietitians, health coaches, in-app trackers,
	regular mental health assessments. IN ; no rollover of credits
	ble Copay listed for outpatient
	gs and 20% Coinsurance IN; 50% Coinsurance OON
	for a one month supply of insulin IN; \$35 Copay OON
\$30 (except \$0 for diabetic retinal eye exam); 35% Coinsurnace OON	\$25 (except \$0 for diabetic retinal eye exam); 25% Coinsurance OON ance OON (One every year)
\$200 Allowance for routine eyewear	\$200 Allowance for routine eyewear
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
	ne every year)
Two Hearing Aids every year; TruHearing Advanced — \$499 Copay; TruHearing Premium — \$799 copay	Two Hearing Aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay
Office: \$0 Copay IN; \$0 Copay OON (One every six months) Includes exam, and cleaning X-ray: \$0 Copay IN (One every year); \$0 Copay OON	Office: \$0 Copay IN; \$0 Copay OON (One every six months) Includes exam, and cleaning X-ray: \$0 Copay IN (One every year); \$0 Copay OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
Comprehensive maximum allowance of \$2000	Comprehensive maximum allowance of \$2000
Restorative Services, Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance IN/OON. Periodontal cleanings/maintenance: \$0 Copay IN/OON, all other periodontal services: 50% Coinsurance IN/OON. Adjunct general services (Palliative only): 50% Coinsurance IN/OON. See EOC for benefit limits.	Restorative Services, Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance IN/OON. Periodontal cleanings/maintenance: \$0 Copay IN/OON, all other periodontal services: 50% Coinsurance IN/OON. Adjunct general services (Palliative only): 50% Coinsurance IN/OON. See EOC for benefit limits.
\$15 Copay IN; 35% Coinsurance OON	\$15 Copay IN; 25% Coinsurance OON
\$15 Copay IN (12 per plan year); 25% Coinsurance OON	\$15 Copay IN (12 per plan year); 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON \$30 Copay IN; 35% Coinsurance OON (three visits)	\$25 Copay IN; 25% Coinsurance OON \$25 Copay IN; 25% Coinsurance OON (three visits)
Cardiac Rehab: \$5 Copay IN; 35% Coinsurance OON	Cardiac Rehab: \$15 Copay IN; 25% Coinsurance OON
Partial Hospital: \$55 copay IN; 35% Coinsurance OON	Partial Hospital: \$55 copay IN; 25% Coinsurance OON
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON N/A	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON N/A
	DRUGS
Fundamental	Fundamental
\$0	\$0
Preferred Retail: Tier 1: \$4, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$9, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$13, Tier 3: \$47, Tier 4: \$99, Tier 5: 33%
Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33%	Preferred Mail: Tier 1: \$0, Tier 2: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$32.50, Tier 3: \$117.50, Tier 4: \$247.50, Tier 5: 33%
	s the full cost for covered Part D drugs.
Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

WNY Growth Product Highlights

Senior Blue Basic HMO

All WNY counties

\$0 premium with generous giveback and affordable medical copays that also provides access to both of Western New York's major health systems.

- \$71 Part B giveback
- \$10 lab and diagnostic IN
- \$1,000 dental allowance
- \$0 Tier 1 drugs
- \$2,250 inpatient hospital annual OOP max

BlueSaver HMO

All WNY counties

\$0 plan with competitive medical and prescription benefits that provides to both of Western New York's major health systems — great for the cost-conscious consumer who wants to balance budget with quality benefits.

- \$0 PCP and lab IN
- \$2,000 dental allowance
- \$0 Tier 1 drugs
- \$2,100 inpatient hospital annual OOP max

Freedom Nation PPO

All WNY counties

Low-premium plan with robust medical and prescription benefits for the members who are looking for flexibility and strong supplemental benefits.

- \$0 PCP IN
- \$5 lab IN and OON
- \$2,000 dental allowance
- \$0 Tier 1 drugs
- \$2,250 inpatient hospital annual OOP max

NEW PLAN

Freedom Nation Prestige PPO

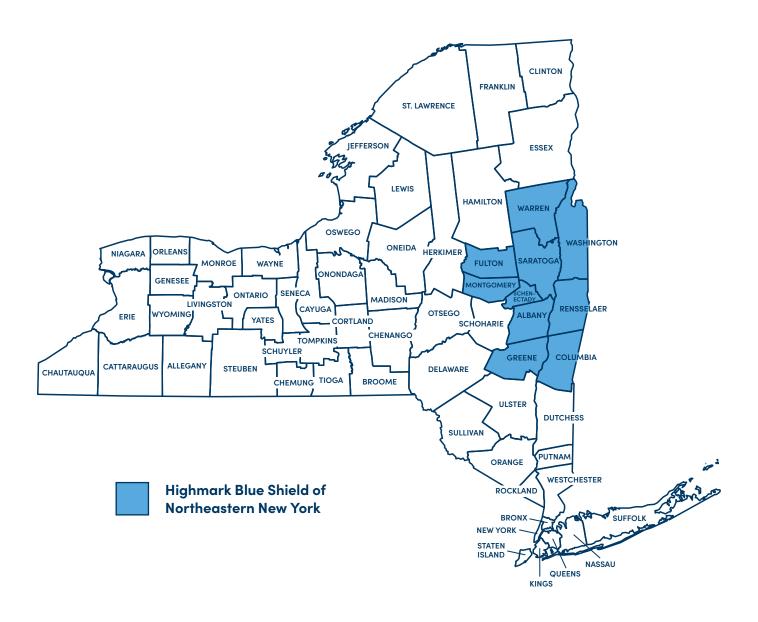
All WNY counties

Mid-priced plan with market leading medical copays and broad network access in Western New York. Great for Medigap switchers and consumers looking for predictability and enhanced supplemental benefits for an affordable premium.

- \$0 PCP IN
- \$0 lab IN and OON
- \$10 specialist and PT IN
- \$3,000 dental allowance
- \$0 Tier 1 and 2 drugs
- \$1,830 inpatient hospital annual OOP max IN

PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals

Highmark Blue Shield of Northeastern New York



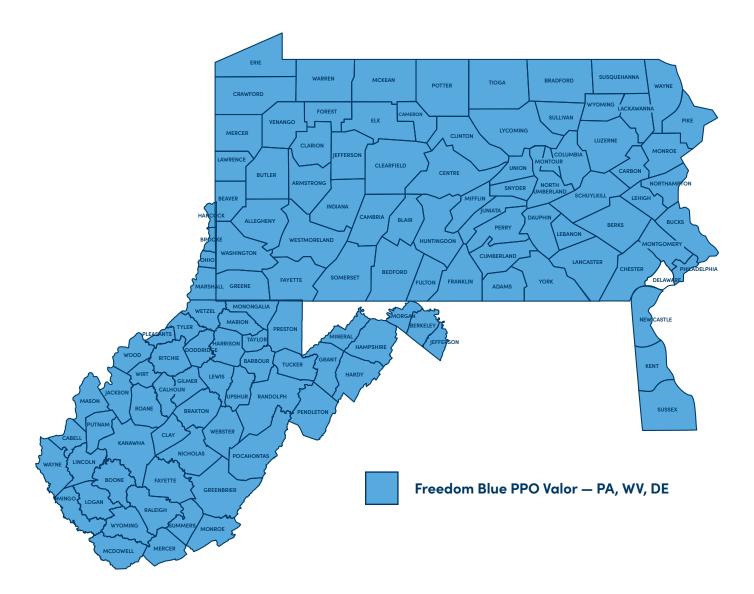
^{*}Pricing is subject to CMS approval

Highmark Blue Shield of Northeastern New York (Products and pricing by county)

	FREEDOM PLUS HMO	SENIOR BLUE 652 HMO
Monthly Plan Premium	\$37	\$107
Part B Premium Buyback	\$0	\$0
Out-of-Pocket Maximum	Network: \$6,700; Combined: N/A	Network: \$6,700; Combined: N/A
PCP Office Visit	\$0 -\$10 Copay IN	\$0 Copay IN
Specialist Office Visit	\$35 Copay IN	\$26 Copay IN
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$5 lab Copay IN; \$50 diagnostic test copay IN
Lab and Diagnostic Tests (Outpatient Facility)	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$5 lab Copay IN; \$50 diagnostic test copay IN
X-rays	\$50 Copay IN	\$50 Copay IN
Radiation Therapy Advanced Imaging	20% Coinsurance IN \$200 Copay IN	20% Coinsurance IN \$150 Copay IN
Preventive/Screening	\$0 Copay IN	\$0 Copay IN
Outpatient Physical and Speech Therapy	\$25 Copay IN	\$15 Copay IN
Medicare Covered Acupuncture	\$35 Copay IN	\$26 Copay IN
Outpatient Occupational Therapy	\$25 Copay IN	\$15 Copay IN
Outpatient Mental Health	\$40 Copay IN	\$40 Copay IN
Outpatient Substance Abuse	\$40 Copay IN	\$40 Copay IN
Outpatient Surgical	ASC: \$230 Copay IN; Facility: \$330 Copay IN	ASC: \$200 Copay IN; Facility: \$300 Copay IN
Ambulance	\$275 Copay	\$200 Copay
Transportation		/A
Emergency Room	\$125.0	
Urgent Care Inpatient Hospital Stay (COVID-19 cost share waiver has been	\$55 C	opay
removed)	\$325 per day for days 1 – 4, \$1,300 OOP Max per year	\$225 per day for days 1 – 7, \$1,575 OOP Max per year
Inpatient Psychiatry Stay	\$275 per day for days 1 – 6, \$1,650 OOP Max per year	\$260 per day for days 1 – 6, \$1,560 OOP Max per year
Skilled Nursing Facility	\$0 per day for days 1 – 20; \$214 per day for day	
Home Health		pay IN
Diabetic Supplies and Services		pay IN
	Diabetic glucometer, test strip, and lancet brands dispensed via r Continuous glucose monitors, sensors and transmitters dispensed v	etail or mail order pharmacy are limited to LifeScan® and Roche®. ria retail or mail order pharmacy are limited to Abbott and Dexcom. Medicare Equipment (DME) provider (or an exception process.).
Durable Medical Equipment	\$0 compression stockings, diabeti	shoes/inserts; 20% all other items
отс	\$70 quarterly allowance	\$60 quarterly allowance
Flex Card	N/A	N/A
Meal Benefit	\$0 copay, one meal per day for seven days upon discharge fron activated within 30	n an inpatient hospital, SNF or Inpatient Psychiatry stay. Must be
Onduo		ee an endocrinologist and receive a glucometer with an unlimited
Spring Health		in-person and virtual clinical support to help members address
CHF and COPD Management powered by Vida	\$0 program for COPD and Congestive Heart Failure to manage con health coaches, lessons on symptom monitoring, and	ndition through an app. Members will receive help from dietitians, in-app trackers,
Fitness Benefit		no rollover of credits
Additional Telehealth Services	Services covered with applica	ble Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B		s and 20% Coinsurance for all other Part B drugs IN
Part B Drugs — Insulin		35 copay for a one month supply of insulin
Medicare Covered Vision (Office Visit)	\$35 (except \$0 for diabetic retinal eye exam)	\$26 (except \$0 for diabetic retinal eye exam)
Routine Vision (Office Visit) Routine Vision (Eyewear)	\$25 Copay IN; Benefit is carved out \$200 Allowance IN; Benefit is carved out to Davis Vision	\$200 Allowance IN; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	\$35 Copay IN	\$200 Allowance IN; Benefit is carved out to Davis vision \$26 Copay IN
Routine Hearing Exam	\$45 Copay (One every year)	\$45 Copay (One every year)
Routine Hearing (Hearing Aids)	Two Hearing Aids every year; TruHearing Advanced	
Routine Dental	• • • • • • • • • • • • • • • • • • • •	<u> </u>
	Office: \$0 Copay IN (One every six months) Includes ex	am and cleaning; X-ray: \$0 Copay IN (One every year)
Medicare Covered Comprehensive Dental	\$35 Copay IN	\$26 Copay IN
Dental Allowance — Preventive and/or Comprehensive		um allowance of \$2000
Comprehensive Dental — Supplemental	Restorative, Endodontics, Prosthodontics, Oral/Maxillofacial Surg Copay IN, all other pare covered at 50% IN. Adjunctive Coparal Services 50% P.	
Medicare Covered Chiropractic		pay IN
Routine Chiropractic	\$15 Copay IN (12 per plan year)	\$15 Copay IN (12 per plan year)
Medicare Covered Podiatry	\$35 Copay IN (12 per plair year)	\$26 Copay IN
Routine Podiatry	\$35 Copay IN (three visits)	\$26 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital,	Cardiac Rehab: \$15 Copay IN	Cardiac Rehab: \$10 Copay IN
Outpatient Blood	Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN	Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN
Combined Acupuncture and Massage Therapy Allowance	N/A	N/A
	PART D DRUGS	
Formulary	Fundamental	Fundamental
Deductible	\$0	\$0
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply.	Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33%
Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Standard Retail: Tier 1: \$7, Tier 2: \$13, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up	Preferred Mail: Tier 1: \$0, Tier 2: \$20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33%
to 31-days supply)	Standard Mail: Tier 1: \$17.50, Tier 2: \$32.50, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Standard Mail: Tier 1: \$17.50, Tier 2: \$37.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33%
OOP Threshold	\$2,000. Once that is met, the plan pays	s the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order
	pharmacy	pharmacy

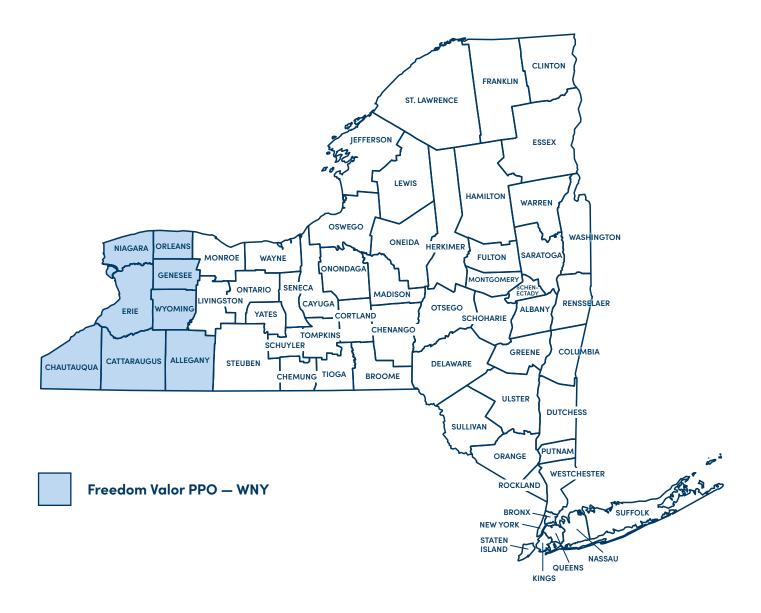
FOREVER BLUE 770 PPO
\$198
\$0 Network: \$6,700; Combined: \$10,000
Network, 36,700, Committee, 310,700 \$0.95 Coppay (N); 25% Coinsurance OON
\$22 Copay IN; 25% Coinsurance OON
\$5 lab Copay IN; \$5 copay OON; \$40 diagnostic test copay IN; 25% Coinsurance OON
\$5 lab Copay IN; \$5 copay OON; \$40 diagnostic test copay IN; 25% Coinsurance OON \$40 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 25% Coinsurance OON 20% Coinsurance IN; 25% Coinsurance OON
\$150 Copy IN; 25% Coinsurance OON
\$0 Copay IN; 30% Coinsurance OON
\$15 Copay IN; 25% Coinsurance OON
\$22 Copay IN; 25% Coinsurance OON \$15 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON
ASC: \$175 Copay IN; 25% Coinsurance OON; Facality: \$275 Copay IN; 25% Coinsurance OON
\$300 Copay N/A
\$125 Copay
\$55 Copay
IN: \$205 per day for days 1 – 7, \$1,435 OOP Max per year; OON: 30% Coinsurance
IN: \$270 per day for days 1 – 6, \$1,620 OOP Max per year; OON: 30% Coinsurance
IN: \$0 per day for days 1 – 20; \$214 per day for days 21 – 100, No yearly benefit period maximum. OON: 30% Coinsurance
\$0 Copay IN; 25% Coinsurance OON
\$0 Copay IN Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to LifeScan® and Roche®.
Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom.
All other desired brands will need to be obtained from a Durable Medicare Equipment (DME) provider (or an exception process.).;
50% coinsurance OON IN: \$0 compression stockings, diabetic shoes/inserts; 20% all other items; OON: 50% Coinsurance
\$65 quarterly allowance
N/A
\$0 copay, one meal per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay.
Must be activated within 30 days of discharge. \$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer
with an unlimited supply of test strips IN
\$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help
members address behavioral health needs. IN
\$0 program for COPD and Congestive Heart Failure to manage condition through an app. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments. IN
32 credits per month; no rollover of credits
Services covered with applicable Copay listed for outpatient
0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON 20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; \$35 Copay OON
\$22 (except \$0 for diabetic retinal eye exam); 25% coinsurance OON
\$25 Copay IN; 20% coinsurance OON; Benefit is carved out to Davis Vision
\$200 Allowance IN and OON Combined; Benefit is carved out to Davis Vision
\$22 Copay IN; 25% Coinsurance OON \$45 Copay (One every year)
Two Hearing Aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay
Office: \$0 Copay IN; \$0 Copay OON (One every six months) Includes exam, and cleaning;
X-ray: 90 Copay IN (One every year); 90 Copay OON
\$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000
Restorative, Endodontics, Prosthodontics, Oral/Maxillofacial Surgery: 50% Coinsurance IN and OON. Periodontal cleanings/
maintenance \$0 Copay IN and OON, all other periodontal services are covered at 50% IN and OON.
Adjunctive General Services: 50% Palliative IN and OON, All others not coverd IN and OON. See EOC for benefit limits.
\$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON
\$22 Copay IN; 25% Coinsurance OON
\$22 Copay IN; 25% Coinsurance OON (three visits)
Cardiac Rehab: \$15 Copay IN; 25% Coinsurance OON
Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 30% Coinsurance OON
N/A
PART D DRUGS
Fundamental
\$0
Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: 25%, Tier 4: 39%, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: 25%, Tier 4: 39%, Tier 5: 33%
Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: 25%, Tier 4: 39%, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$37.50, Tier 3: 25%, Tier 4: 39%, Tier 5: 33%
\$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.
Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

Freedom Blue PPO Valor — PA, WV, DE



^{*}Pricing is subject to CMS approval

Freedom Valor PPO — WNY



Freedom Blue PPO Valor — PA, WV, DE Freedom Valor PPO — WNY

Trip limit wolved if trip is part of continued acute care after discharge from IE. Herragnary Reem 315 Coppy 315 Coppy 315 Coppy 316 Coppy 317 Coppy 317 Coppy 317 Coppy 318 C		FREEDOM BL	JE PPO VALOR
Delt-st Pricket Meximum Network 16,000 Cambridge 18,350 Network 16,000 Carbon 18,350 Network 16,000 Carbon 18,350 Network 16,000 Carbon 18,350 Network 18,350 Ne			
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Specialist of The Visit			
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Lob and Diagnostic Tests (Outperland Facility) 50 Cappy NI, 835 Cappy CON 50 Cappy N		\$10 Copay IN; \$10 Copay OON	\$10 Copay IN; \$10 Copay OON
Statistion Receipt 350 Clapson Ni, 1950 Clapson (Os) 420 Clapson Ni, 1950 Clapson (Os) 427 Clapson Ni, 1950 Clapson (Os) 428 Clapson Ni, 1950 Clapson (Os) 429 Clapson Ni, 1950 Clapson (Os) 429 Clapson Ni, 1950 Clapson (Os) 420 Clapso		\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$35 Copay OON
Sederland havenger			
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Outpelforest Surgical ASC \$900 Coppy NB, \$255 Coppy CON Profits Star Coppy CON Archdulance Archdulance Archdulance Archdulance Archdulance Archdulance Berry Coppy Star Coppy CON Non-Emergent 30C Contraverse CON Non-Emergent			
Ambulance Feelily, \$286 Coppy IK, \$372 Coppy CON Franspare Room F		\$5 Copay IN; \$35 Copay OON	
Ambalance Remergent/Non-Emergent 350 N Emergent/Non-Emergent 350 N Emergent/Non-Emergent 350 Color	Outpatient Surgical		
Transportation 80 Cappy IN 30 Colimurance OON. Up to 24 non-way frig. Trip limit voice of the pin part of combinal double can will be continued could core of the Cappy (19 continued the Cappy (19 continued could core of the Cappy (19 continued could continued c	Ambulance	Emergent/Non-Emergent: \$250 IN	Emergent/Non-Emergent: \$250 IN
Emergency Room \$150 Coppy \$150 Coppy \$150 Coppy \$150 Coppy \$100 Coppy	Transportation	\$0 Copay IN; 30% Coinsurance OON. Up to 24 one-way trips. Trip limit waived if trip is part of continued acute care after	\$0 Copay IN; 30% Coinsurance OON. Up to 24 One-way trips. Trip limit waived if trip is part of continued acute care after
Inpatient Psychiatry Stay \$2575.64cy (days 1-3, \$304cy (days 2-40) N. \$3575.64cy (days 1-3, \$304cy (days 2-40) N. \$4575.64cy (days 1-3, \$304cy (d	Emergency Room	\$125 Copay	\$125 Copay
Inpolient Psychiatry Stoy \$252 days (days 1 - 3) (340 yell (gays 1 - 3) (350 yell (gays 1 - 3) (ga		\$50 Copay	\$40 Copay
Silled Nursing Facility 50/40y (days 1 - 20), 80/40y (days 4 - 90) CON 50/40y (days 1 - 20), 80/40y (days 4 - 90) CON 50/40y (days 1 - 20), 82/44/day (days 4 - 100) N; 50/40y (days 1 - 20), 82/44/day (days	· , ,	-	<u>'</u>
Skilled Murriag Facility Sind Syd (spays 1 – 20); \$214/409 (spays 1 – 100) IN; 30 Consumance OND Disbellic Lyppies and Services Of Coinsurance of Ord better supplies received via retail or mail order pharmosy imited to Abbott and LifeScan, all other braids are sensor and frommittee supplies received via retail or mail order pharmosy are limited to Abbott and LifeScan, all other braids are sensor and frommittee supplies are served via retail or mail order pharmosy are limited to Abbott and Descon, 20% coinsurance for all other pharmosy are limited to Abbott and Descon, 20% coinsurance for all other pharmosy are limited to Abbott and Descon, 20% coinsurance for all other covered diabbits caused via retail or real order pharmosy are limited to Abbott and Descon, 20% coinsurance for all other covered diabbits caused via retail or real order pharmosy are limited to Abbott and Descon, 20% coinsurance for all other covered diabbits caused via retail or real order pharmosy are limited to Abbott and Descon, 20% coinsurance ON Durable Medical Equipment 20% Coinsurance IN, 30% Coinsurance ON To Sid	Inpatient Psychiatry Stay	\$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	475/day (days 1 – 3), \$0/day (days 4 – 90) OON
Home Health Diabetic Supplies and Services OTC. Girsurance for Mischet Supplies received via retail or mail of carbon from the supplies received via retail or mail or during plant may be inhered the supplies received via retail or mail or during plant may be inhered the supplies received via retail or mail or during plant may be inhered through a DMB Supplies, continuous glucoses menitors, sensors and fromshifters dispensed via retail or mail order pharmacy are limited to Abbot and Dexoco, 703, consurance for all other covered diabetic supplies in the Supplies received frough to DMB Supplies, continuous glucoses menitors, and the covered diabetic supplies in the Supplies received frough to DMB Supplies, continuous color and the covered diabetic supplies in the Supplies received frough to DMB Supplies, continuous color and the covered diabetic supplies in the Supplies received frough to DMB Supplies, continuous color and the covered diabetic supplies in the Supplies received from the Supplies received frough to DMB Supplies, continuous color and the covered diabetic supplies in the Supplies received frough to DMB Supplies continuous color and the Covered diabetic supplies in the Supplies received from the Supplies received from the Supplies received from the DMB Supplies continuous colors and the Supplies received from th	Skilled Nursing Facility	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN; 30% Coinsurance OON	\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN;
O'S. Coinsurance for diabetic supplies received via retail or mail order phermacy primited the Abbott and Libesce, and either branch and phermacy primited the Abbott and Libesce, and either branch are presented as the phermacy primited the Abbott and Libescen, all other branch are provided phermacy are limited to Abbott and Discore, 70% coinsurance for all other phermacy are limited to Abbott and Discore, 70% coinsurance for all other phermacy are limited to Abbott and Discore, 70% coinsurance for all other covered diabetic supplies (R) 30%. Coinsurance ON and the Abbott and Discore, 70% coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other covered diabetic supplies (R) 30%. Coinsurance ON and all other			
OTC S100 Allowance Once Per Quarter Fixe Card N/A	Substitute Cappines and Services	order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON
Record N/A N	Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON
Medicare Covered Hearing Exam Sol Cappy IN, \$10 Cappy IN, \$10 Cappy (IN) \$10 Cap	OTC.	\$100 All	0 D 0 1
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Routine Dental Office Visit: \$0 Copay IN; 30% Coinsurance OON (One Every Six Months) Includes exam, cleaning, and fluoride treatment X-ray: \$0 Copay IN; 30% Coinsurance OON (One Every Year) Medicare Covered Comprehensive Dental S10 Copay IN; \$10 Copay OON Dental Allowance - Preventive and/or Comprehensive Combined maximum allowance of \$3,000 Comprehensive Dental — Supplemental \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative, 20% All others). 50% Coinsurance OON. See EOC for benefit limits. Medicare Covered Chiropractic \$15 Copay IN; \$35 Copay OON S15 Copay IN; \$35	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs – Chemotherapy and All Other Part B Part B Drugs – Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Membuith an unlimited sure program with digital tool help members address be so program for COPD and Congestive Heart Failure to manage content heart for the program for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for Intention for Part B drugs IN; 30% Coinsurance ON 20% Coinsurance For Part B rebatable drugs and 20% Coinsurance GON 20% Coinsurance up to a maximum of a \$35 copay in \$10 Copay IN; \$10 Copay OON (One Every Year) Standard Eyeglass lenses and frames or contact lenses are covereframes or a \$200 benefit maximum for specialty contact \$10 Copay IN; \$10 Copay OON	N/A N/A N/A N/A N/A N/A N/A N/A
Medicare Covered Comprehensive Dental \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memburth an unlimited sure sure sure sure sure sure sure sure	N/A N/A N/A N/A N/A N/A N/A N/A
Dental Allowance - Preventive and/or Comprehensive Combined maximum allowance of \$3,000 Comprehensive Dental — Supplemental SO Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (\$0 Palliative, 20% All others). 50% Coinsurance OON. See EOC for benefit limits. Medicare Covered Chiropractic \$15 Copay IN; \$35 Copay OON Routine Chiropractic \$15 Copay IN; \$35 Copay OON \$15 Copay IN; \$35 Copay OON \$15 Copay IN; \$35 Copay OON \$10 Copay IN; \$10 Copay	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids)	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memburth an unlimited sure program with digital tool help members address be so program for COPD and Congestive Heart Failure to manage content to the content of t	N/A N/A N/A N/A N/A N/A N/A N/A
So Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (So Pollative, 20% All others). 50% Coinsurance OON. See EOC for benefit limits. Medicare Covered Chiropractic \$15 Copay IN; \$35 Copay OON Routine Chiropractic \$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Copay OON (Eight visits) Redicare Covered Podiatry \$10 Copay IN; \$10 Copay OON (Eight visits)	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure in the program of the program with digital tool help members address be so program for COPD and Congestive Heart Failure to manage acceptable of the program of	N/A N/A N/A N/A N/A N/A N/A N/A
Routine Chiropractic \$15 Copay IN; \$35 Copay OON (Eight visits) \$15 Copay IN; \$35 Copay OON (Eight visits) \$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Co	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs – Chemotherapy and All Other Part B Part B Drugs – Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure sure sure sure sure sure sure sure	N/A N/A N/A N/A N/A N/A N/A N/A
Routine Chiropractic \$15 Copay IN; \$35 Copay OON (Eight visits) \$15 Copay IN; \$35 Copay OON (Eight visits) \$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Co	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance - Preventive and/or Comprehensive	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Membwith an unlimited subth and the program with digital tool help members address be so program for COPD and Congestive Heart Failure to manage and the death of the program for COPD and Congestive Heart Failure to manage and the death and the services covered with applicable and the services covered with applicable and 20% and the services covered with applicable and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON 20% Coinsurance up to a maximum of a \$35 copay to \$10 Copay IN; \$10 Copay OON (One Every Year) Standard Eyeglass lenses and frames or contact lenses are covere frames or a \$200 benefit maximum for specialty contact \$10 Copay IN; \$10 Copay OON (One Every Year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$50 Copay IN; \$30 Copay I	ers can see an endocrinologist and receive a glucometer pply of test strips. IN s, coaching, in-person and virtual clinical support to shavioral health needs. IN and tion through an app. Members will receive help from dietitians, monitoring, and regular mental health assessments. IN 32 credits per month; no rollover of credits st share listed for in-person services 0%-19-99% Coinsurance for Part B rebatable drugs and 20%. Coinsurance for all other Part B drugs IN; 30% Coinsurance OON or a one month supply of insulin IN; 535 Copay OON \$10 Copay IN; 510 Copay OON \$0 Copay IN; \$50 Copay OON (One Every Year) din full. IN/OON: A \$200 benefit maximum applies to non-standard lenses. \$200 benefit maximum for post cataract eyewear. \$10 Copay IN; \$10 Copay OON \$0 Copay IN; \$50 Copay OON (One Every Year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$50 allowance IN/OON for any other hearing aid urance OON (One Every Six Months) and fluoride treatment urance OON (One Every Year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000
Medicare Covered Podiatry \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON Routine Podiatry \$10 Copay IN; \$10 Copay OON (10 visits) \$10 Copay IN; \$10 Copay OON (10 visits) Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood \$0 Copay IN; 30% Coinsurance OON \$0 Copay IN; 30% Coinsurance OON	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance - Preventive and/or Comprehensive Comprehensive Dental — Supplemental	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure sure sure sure sure sure sure sure	N/A N/A N/A N/A N/A N/A N/A N/A
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood \$0 Copay IN; 30% Coinsurance OON \$0 Copay IN; 30% Coinsurance OON PART D DRUGS	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs – Chemotherapy and All Other Part B Part B Drugs – Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance – Preventive and/or Comprehensive Comprehensive Dental – Supplemental Medicare Covered Chiropractic Routine Chiropractic	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure with an unlimited sure program with digital tool help members address be heard for COPD and Congestive Heart Failure to manage content in the program of the program of the program for COPD and Congestive Heart Failure to manage content for COPD and Congestive Heart Failure to manage content for the program of	N/A N/A N/A N/A N/A N/A N/A N/A
Partial Hospital, Outpatient Blood \$0 Copay IN; 30% Coinsurance OON \$0 Copay IN; 30% Coinsurance OON PART D DRUGS	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance - Preventive and/or Comprehensive Comprehensive Dental - Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure with an unlimited sure program for CoPD and Congestive Heart Failure to manage compared to the person of the pe	ers can see an endocrinologist and receive a glucometer pply of test strips. IN s, coaching, in-person and virtual clinical support to shavioral health needs. IN ondition through an app, Members will receive help from dietitians, monitoring, and regular mental health assessments. IN 32 credits per month; no rollover of credits st share listed for in-person services 0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$0 Copay IN; \$10 Copay OON \$0 Copay IN; \$510 Copay OON \$0 Copay IN; \$510 Copay OON \$10 Copay IN; \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay
	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs - Chemotherapy and All Other Part B Part B Drugs - Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance - Preventive and/or Comprehensive Comprehensive Dental — Supplemental Medicare Covered Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Routine Podiatry	N/A N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure with an unlimited sure program for CoPD and Congestive Heart Failure to manage compared to the person of the pe	ers can see an endocrinologist and receive a glucometer pply of test strips. IN s, coaching, in-person and virtual clinical support to shavioral health needs. IN ondition through an app, Members will receive help from dietitians, monitoring, and regular mental health assessments. IN 32 credits per monthy, no rollover of credits st share listed for in-person services 0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON or a one month supply of insulin IN; 335 Copay OON \$10 Copay IN; \$10 Copay OON \$0 Copay IN; \$10 Copay OON \$0 Copay IN; \$10 Copay OON \$0 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay I
Prescription Drug Coverage N/A	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs – Chemotherapy and All Other Part B Part B Drugs – Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance – Preventive and/or Comprehensive Comprehensive Dental – Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Ro	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Membwith an unlimited surith and	ers can see an endocrinologist and receive a glucometer pply of test strips. IN s, coaching, in-person and virtual clinical support to shavioral health needs. IN and tion through an app. Members will receive help from dietitians, monitoring, and regular mental health assessments. IN 32 credits per month; no rollover of credits st share listed for in-person services 0%-19-99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON or a one month supply of insulin IN; 535 Copay OON \$10 Copay IN; 510 Copay OON \$0 Copay IN; 550 Copay OON (One Every Year) din full. IN/OON: A \$200 benefit maximum applies to non-standard lenses. \$200 benefit maximum for post cataract eyewear. \$10 Copay IN; 510 Copay OON (One Every Year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid urance OON (One Every Six Months) and fluoride treatment urance OON (One Every Year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (Palliative). 50% Coinsurance OON. See EOC for benefit limits.
	Flex Card Meal Benefit Onduo Spring Health CHF and COPD Management powered by Vida Fitness Benefit Additional Telehealth Services Part B Drugs – Chemotherapy and All Other Part B Part B Drugs – Insulin Medicare Covered Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Office Visit) Routine Vision (Eyewear) Medicare Covered Hearing Exam Routine Hearing (Hearing Aids) Routine Dental Medicare Covered Comprehensive Dental Dental Allowance – Preventive and/or Comprehensive Comprehensive Dental – Supplemental Medicare Covered Chiropractic Routine Chiropractic Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Ro	N/A N/A N/A N/A S0 Onduo Virtual Diabetes Program for Diabetes. Memb with an unlimited sure sure sure sure sure sure sure sure	ers can see an endocrinologist and receive a glucometer pply of test strips. IN s, coaching, in-person and virtual clinical support to shavioral health needs. IN and tion through an app. Members will receive help from dietitians, monitoring, and regular mental health assessments. IN 32 credits per month; no rollover of credits st share listed for in-person services 0%-19-99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON or a one month supply of insulin IN; 535 Copay OON \$10 Copay IN; 510 Copay OON \$0 Copay IN; 550 Copay OON (One Every Year) din full. IN/OON: A \$200 benefit maximum applies to non-standard lenses. \$200 benefit maximum for post cataract eyewear. \$10 Copay IN; 510 Copay OON (One Every Year) 2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for any other hearing aid urance OON (One Every Six Months) and fluoride treatment urance OON (One Every Year) \$10 Copay IN; \$10 Copay OON Combined maximum allowance of \$3,000 \$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services (Palliative). 50% Coinsurance OON. See EOC for benefit limits.

FREEDOM BLI	JE PPO VALOR	FREEDOM VALOR PPO
\$0	\$0	\$0
WV: \$75	DE: \$70	WNY: \$50
Network: \$6,000; Combined: \$8,950 \$0 Copay IN; \$0 Copay OON	Network: \$6,000; Combined: \$8,950 \$0 Copay IN; \$0 Copay OON	Network: \$6,700; Combined: \$10,000 \$0 Copay IN; 50% Coinsurance OON
\$10 Copay IN; \$10 Copay OON	\$10 Copay IN; \$10 Copay OON	\$35 Copay IN; 50% Coinsurance OON
\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$35 Copay OON	\$0 lab Copay IN; 50% Coinsurance OON \$45 diagnostic test Copay IN; 50% Coinsurance OON
\$0 Copay IN; \$35 Copay OON	\$0 Copay IN; \$35 Copay OON	\$0 lab Copay IN; 50% Coinsurance OON
\$20 Copay IN; \$35 Copay OON	\$20 Copay IN; \$35 Copay OON	\$45 diagnostic test Copay IN; 50% Coinsurance OON \$45 Copay IN; 50% Coinsurance OON
\$60 Copay IN; \$80 Copay OON	\$60 Copay IN; \$80 Copay OON	20% Coinsurance IN; 50% Coinsurance OON
\$225 Copay IN; \$325 Copay OON	\$225 Copay IN; \$325 Copay OON	\$150 Copay IN; 50% Coinsurance OON
Covered in Full (Office visit copay may apply) IN/OON	Covered in Full (Office visit copay may apply) IN/OON	\$0 Copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON \$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$35 Copay OON	\$15 Copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON \$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$35 Copay OON \$15 Copay IN; \$35 Copay OON	\$35 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON
\$5 Copay IN; \$35 Copay OON	\$5 Copay IN; \$35 Copay OON	\$5 Copay IN; 50% Coinsurance OON
\$5 Copay IN; \$35 Copay OON	\$5 Copay IN; \$35 Copay OON	\$5 Copay IN; 50% Coinsurance OON
ASC: \$200 Copay IN; \$325 Copay OON Facility: \$250 Copay IN; \$375 Copay OON	ASC: \$195 Copay IN; \$325 Copay OON Facility: \$245 Copay IN; \$375 Copay OON	ASC: \$225 Copay IN; 50% Coinsurance OON Facility: \$325 Copay IN; 50% Coinsurance OON
Emergent/Non-Emergent: \$300 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$260 IN Non-Emergent: 30% Coinsurance OON	\$250 Copay
\$0 Copay IN; 30% Coinsurance OON. Up to 24 One-way trips. Trip limit waived if trip is part of continued acute care after discharge from ER.	N/A	N/A
\$125 Copay	\$125 Copay	\$125 Copay
\$50 Copay	\$50 Copay	\$55 Copay
\$275/admit IN; \$395/admit OON	\$275/admit IN (SEPA: \$300/admit IN); \$395/admit OON	IN: \$290 per day for days 1 – 7, \$2,030 OOP Max per year OON: 50% Coinsurance
\$325/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	\$325/day (days 1 – 3), \$0/day (days 4 – 90) IN; \$475/day (days 1 – 3), \$0/day (days 4 – 90) OON	IN: \$260 per day for days 1 – 6, \$1,560 OOP Max per year OON: 50% Coinsurance
\$0/day (days 1 – 20); \$214/day (days 21 – 100) IN;	\$0/day (days 1 – 3); \$214/day (days 21 – 100) IN;	IN: \$0 per day for days 1 – 20; \$214.00 per day for days 21 – 100,
30% Coinsurance OON	30% Coinsurance OON	No yearly benefit period maximum. 50% Coinsurance OON
\$0 Copay IN; 30% Coinsurance OON	\$0 Copay IN; 30% Coinsurance OON	\$0 Copay IN; 50% Coinsurance OON \$0 Copay IN
0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies IN; 30% Coinsurance OON	Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to LifeScan® and Roche®. Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom. All other desired brands will need to be obtained from a Durable Medicare Equipment (DME) provider (or an exception process.); 50% coinsurance OON
20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON	IN: \$0 compression stockings, diabetic shoes/inserts; 20% all other items; OON: 50% Coinsurance
\$100 Allowance Once Per Quarter	\$100 Allowance Once Per Quarter	\$25 quarterly allowance
N/A	N/A	N/A \$0 for one meal per day for 7 days upon discharge from an
N/A	N/A	inpatient hospital, SNF or Inpatient Psych stay. Must be activated within 30 days of discharge.
\$0 Onduo Virtual Diabetes Program for Di	abetes. Members can see an endocrinologist and receive a glucomet	ter with an unlimited supply of test strips IN
\$0 behavioral health care program with di	gital tools, coaching, in-person and virtual clinical support to help me	mbers address behavioral health needs. IN
	lure to manage condition through an app. Members will receive help sons on symptom monitoring, and regular mental health assessments	
32 credits per month; no rollover of credits	32 credits per month; no rollover of credits	32 credits per month; no rollover of credits
	ervices covered with applicable cost share listed for in-person service	
0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 50% Coinsurance OON
\$10 Copay IN; \$10 Copay OON	up to a maximum of a \$35 copay for a one month supply of insulin IN \$10 Copay IN; \$10 Copay OON	; \$35 Copay OON \$35 (except \$0 for diabetic retinal eye exam); 50% coinsurance OON
\$0 Copay IN; \$50 Copay OON (One Every Year)	\$0 Copay IN; \$50 Copay OON (One Every Year)	\$25 Copay IN; 20% Coinsurance OON (One Every Year)
Standard Eyeglass lenses and frames or contact lenses are covered	d in full. IN/OON: A \$200 benefit maximum applies to non-standard	\$100 Allowance for routine eyewear
frames or a \$200 benefit maximum for specialty contact \$10 Copay IN; \$10 Copay OON	enses. \$200 benefit maximum for post cataract eyewear. \$10 Copay IN; \$10 Copay OON	\$35 Copay IN; 50% Coinsurance OON
\$10 Copay IN; \$10 Copay OON \$0 Copay IN; \$0 Copay OON (One Every Year)	\$10 Copay IN; \$10 Copay OON \$0 Copay IN; \$0 Copay OON (One Every Year)	\$45 Copay (One Every Year)
2 Hearing Aids Every year; TruHearing Advanced — \$699 copay;	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay IN; \$500 allowance IN/OON for	2 Hearing Aids Every year; TruHearing Advanced — \$699 copay;
any other hearing aid	any other hearing aid	TruHearing Premium — \$999 copay
Includes exam, cleaning	urance OON (One Every Six Months) , and fluoride treatment	Office: \$0 Copay IN; \$0 Copay OON (One Every Six Months) Includes exam, cleaning and flouride treatment
\$10 Copay IN; \$10 Copay OON	urance OON (One Every Year) \$10 Copay IN; \$10 Copay OON	X-Ray: \$0 Copay IN (One Évery Year); \$0 Copay OON \$35 Copay IN; 50% Coinsurance OON
Combined maximum allowance of \$2,000	Combined maximum allowance of \$3,000	Combined maximum allowance of \$2000
Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 20% Coinsurance IN. Adjunct general services: Palliative 0%, and all others 20% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Restorative, Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative–40% All Others IN, 50% Palliative–40% All Others OON. See EOC for benefit limits.	Restorative Services: medicament application 0%, all others 50% coinsurance IN. All services: 50% Coinsurance IN. All services: 50% Coinsurance ON. Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% Coinsurance IN/OON, Periodontal cleanings/maintenances 0 Copay IN/OON, all other periodontal services: 50% Coinsurance IN/OON Adjunct general services: palliative 0% Coinsurance, all others: 50% Coinsurance IN; All services: 50% Coinsurance ON. See EOC for benefit limits.
\$1E Congres INC \$2E Communication	\$15 Copay IN; \$35 Copay OON	\$15 Copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON		\$15 Copay IN (6 per plan year); 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON (Eight visits)	\$15 Copay IN; \$35 Copay OON (Eight visits)	
\$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Copay OON	\$10 Copay IN; \$10 Copay OON	\$35 Copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON (Eight visits)		\$35 Copay IN; 50% Coinsurance OON \$35 Copay IN; 50% Coinsurance OON (3 visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (10 visits)	\$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	\$35 Copay IN; 50% Coinsurance OON \$35 Copay IN; 50% Coinsurance OON (3 visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON
\$15 Copay IN; \$35 Copay OON (Eight visits) \$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (10 visits)	\$10 Copay IN; \$10 Copay OON \$10 Copay IN; \$10 Copay OON (10 visits)	\$35 Copay IN; 50% Coinsurance OON \$35 Copay IN; 50% Coinsurance OON (3 visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON

Valor Product Highlights

\$0 MA only plan with strong medical, first \$ Dental, Vision, Hearing, Fitness, and a generous Part B Giveback to assist with the overall cost of healthcare. Great for Veterans or other Medicare beneficiaries who have prescription coverage elsewhere and are looking for additional flexibility and peace of mind.

Freedom Blue PPO Valor

PA*, WV, DE
*excludes Delaware county

Part B giveback		
WPA, CPA, NEPA, WV	\$75	
SEPA	\$60	
DE	\$70	

Plan benefits also include:

- \$0 PCP IN and OON
- \$10 specialist IN and OON
- \$5 mental health IN
- Per stay inpatient hospital
- Up to \$3,000 dental allowance
- \$100 per quarter OTC allowance

Freedom PPO Valor

WNY

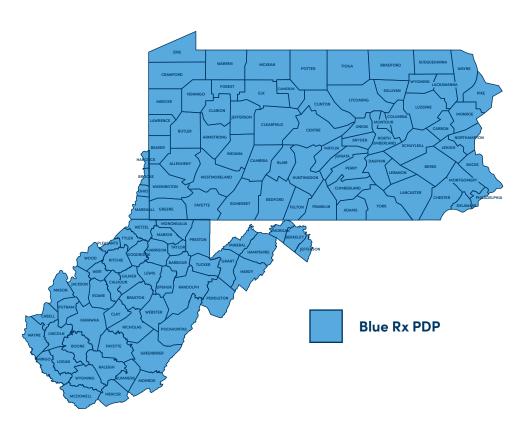
Part B giveback	
WNY	\$75

Plan benefits also include:

- \$0 PCP and lab IN
- \$5 mental health IN
- \$15 PT and OT IN
- \$2,000 dental allowance
- \$25 quarterly OTC allowance includes brand name items

All PPO Plans include BlueCard access to BCBSA's national network of doctors and hospitals

Blue Rx PDP — PA, WV



Blue Rx PDP — PA, WV (Products and pricing by county)

	PLUS	COMPLETE
Monthly Plan Premium	\$143.20	\$168.20
Deductible	\$590	\$0
Formulary	Base (Venture)	Base (Venture)
Initial Coverage Limit. Retail: Cost sharing is for up to 31-day supply.	Preferred Retail: \$0 Pref. Gen, \$7 Generic, 24% Pref. Brand,	Preferred Retail: \$0 Pref. Gen, \$5 Generic, 25% Pref. Brand,
Can get up to 100-day supply for T1 and T2 and 90-day supply for	40% Non-pref. Drug, 25% Specialty	49% Non-pref. Drug, 33% Specialty
T3 and T4 at 3x copay, except Specialty Tier 5.	Standard Retail: \$5 Pref. Gen, \$12 Generic, 24% Pref. Brand,	Standard Retail: \$4 Pref. Gen, \$10 Generic, 25% Pref. Brand,
	50% Non-pref. Drug, 25% Specialty	49% Non-pref. Drug, 33% Specialty
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to	Preferred Mail: Tier 1: \$0, Tier 2: \$17.50, Tier 3: 24%, Tier 4: 40%, Tier 5: 25%	Preferred Mail: Tier 1: \$0, Tier 2: \$12.50, Tier 3: 25%, Tier 4: 49%, Tier 5: 33%
a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Standard Mail: Tier 1: \$10, Tier 2: \$30, Tier 3: 24%, Tier 4: 50%, Tier 5: 25%	Standard Mail: Tier 1: \$10, Tier 2: \$25, Tier 3: 25%, Tier 4: 49%, Tier 5: 33%
OOP Threshold	\$2,000. Once that has been met, the plan pays the full cost for covered Part D drugs.	
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	

PRODUCTS AND PRICING BY COUNTY | MEDICARE ADVANTAGE

Highmark Medicare Plan Perks

Below is a list of unique advantages that come with a Highmark Medicare plan.

Members of certain Highmark Medicare plans have access to special programs and services designed to improve wellness and manage health conditions.

Exclusive Highmark Medicare plan membership benefits and services include:

- Highmark Clinical Care Team: This group of medical professionals works together to help you manage your health. This collaborative team consists of physicians, pharmacists, social workers, medical case managers, and disease managers.
- Blues On Callsm: Highmark's health coaches are available 24/7 to answer general medical questions.
 - Help your clients understand a recent diagnosis, treatment options, or lab tests.
 - Review your clients' symptoms and help them decide where to receive care.
 - Ensure that your clients are taking medications properly.
 - Provide support for losing weight, managing stress, or quitting smoking.
 - Answer medical questions and provide information.

To speak to a health coach 24 hours a day, seven days a week, call **888-258-3428**.

- My Healthy Flex Card: Available on limited plans. This benefit provides a debit card with an annual allowance that can be used for the out-of-pocket costs associated with eligible benefits, such as hearing, vision, dental, and OTC. With some plans, the allowance can also be used for part B benefits (please note that there is a \$50 limit per transaction for Part B benefits). All Flex benefits are Pre-Allowance, meaning clients can use their funds on the first out-of-pocket expenses and do not have to exhaust the equivalent stand-alone benefit allowances.
- AIS Home Visit Program: When dealing with a serious medical condition, we can provide an extra

layer of support in your home to help you and your family throughout the course of your illness. Advanced Illness Services are available 24 hours a day, seven days a week to help your clients focus on what matters most to them. Learn more about the services provided by the AIS Home Visit Program by contacting 877-317-0216.

- Highmark House Call: Once a year, a licensed health care provider will come to your client's home to review their medications, answer healthrelated questions, and make sure their medical history is current.
- Blue Neighbors: This volunteer program provides nonmedical assistance to Highmark members in need. Volunteers are able to assist with everyday activities such as grocery shopping, household chores, yard work, light meal preparation, errands, and friendly phone calls or visits. To find out more about this program, please call 800-988-0706, 8:30 a.m. – 4:30 p.m., Monday – Friday.
- FitOn: This benefit provides in-person access to fitness and wellness classes at health clubs across the country and virtual classes online at no cost. Members can get fit, make friends, and live a healthier, more active life with this program. The benefit provides access to over 13,000 fitness facilities and community centers with cardio and weight equipment, pools, saunas, and exercise classes. Members receive 32 credits each month to use towards memberships/classes at these gyms and fitness facilities. They will be responsible for all fees that exceed the monthly credit balance. Unused credits will not roll over to the following month. Members must create an account online, via mobile app, or website and then select the fitness facility. They may also contact Member Service for assistance in creating an account. The website and app provides Hollywood production quality fitness classes, custom meal planning, condition-specific courses, and an online community. Call 1-855-946-4036 to take advantage of this valuable program.
- Highmark Wellness Rewards Program: With our rewards program benefits, your clients can earn gift cards for taking positive actions that promote health and well-being.

Value-Added Benefits

Mental Well-Being

Our Mental Well-Being solution, powered by Spring Health, connects members to the most appropriate care based on their individual needs. This program provides fast access to behavioral health providers and high-quality options, from preventive care to clinical support. Members will take an assessment to create a personalized plan and get recommended resources like personalized care plans, in-network therapy, medication management, coaching, and self-guided mental exercises.

Well360 Virtual Health

Well360 Virtual Health is a virtual care solution that provides urgent care, behavioral health, dermatology, and women's health services. Members will easily and seamlessly access the entire suite of Well360 Virtual Health clinics through our fully integrated My Highmark experience. Well360 Virtual Health is available to MA members as a part of their medical benefits.

Benefits include:

- On-demand or scheduled appointments.
- Easy access to all clinics via the My Highmark app and website.
- Ability to route members to in-network services for in-person care and lab work.
- High member satisfaction ratings (75% member satisfaction and 89% ease of use).*
- Access, convenience, and time savings for members.
- Faster-time-to-treatment options with dermatology and behavioral health.

Value-Added Benefits, cont.

Kidney Care Management

Individuals with chronic kidney disease and end-stage renal disease have complex treatment plans that often result in high-cost utilization and poor and frustrating member experiences. Kidney Care Management powered by Healthmap supports your clients and providers with improved care coordination and hightouch personalized services. Available at no additional cost through their Highmark health plan, your clients have access to a Care Navigation team that works hand in hand with their doctor. The Care Navigation team can help them better understand their condition, answer questions about medication, help manage and schedule doctor visits and treatment appointments, and connect them with community services for services like meals and transportation. Eligible members may receive outreach by our Healthmap team.

CHF and COPD Management

CHF and COPD Management, powered by Vida, helps individuals with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) better manage their condition and reduce or avoid hospital admissions, readmissions, and ER visits. This virtual solution allows your clients to learn how to recognize, manage, and monitor their symptoms with the help of registered dietitians, health coaches, in-app trackers, learning resources, and monitoring devices. When needed, an enrolled participant has access to digital scales, blood pressure monitoring devices, and respiratory tracking devices.

^{*}Source: Highmark BoB 2022. Value-Added Benefits may vary by product and plan year.

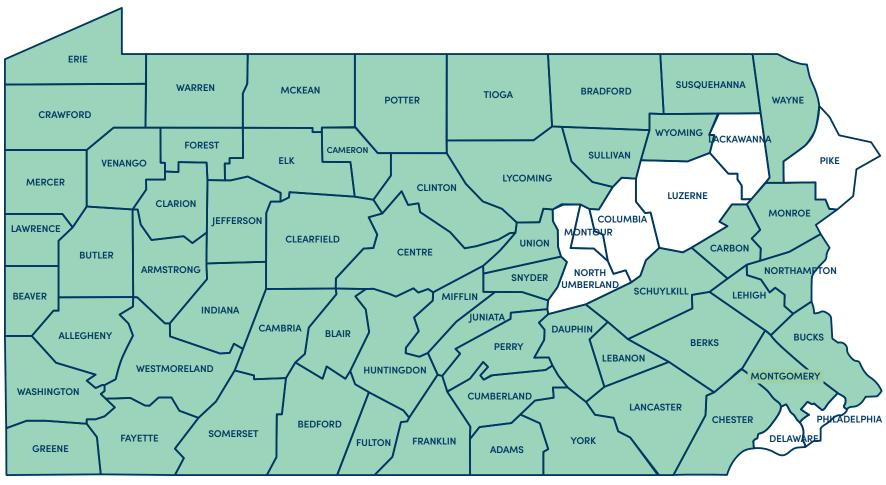
PRODUCTS AND PRICING BY COUNTY

D-SNP

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Highmark Wholecare Medicare Assured Diamond and Ruby



Highmark Wholecare Medicare Assured Diamond and Ruby

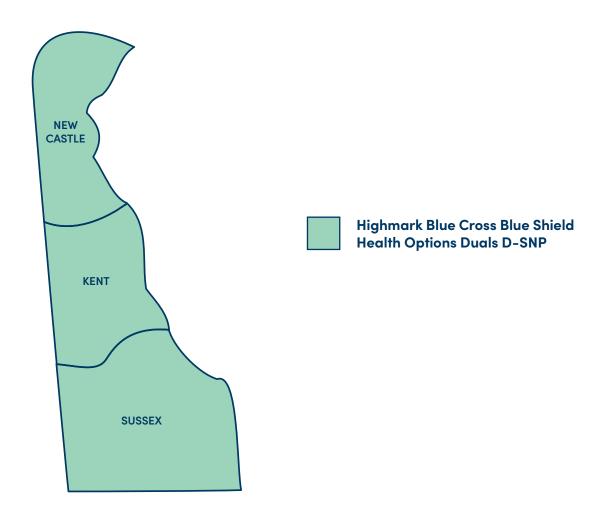
Highmark Wholecare Medicare Assured Diamond and Ruby (Products and pricing by county)

	HIGHMARK WHOLEGARE MEDICARE ASSURED DIAMOND	HIGHMARK WHOLEGARE MEDICARE ASSURED BURY		
Manthly Dina Descriptor	HIGHMARK WHOLECARE MEDICARE ASSURED DIAMOND	HIGHMARK WHOLECARE MEDICARE ASSURED RUBY		
Monthly Plan Premium Out-of-Pocket Maximum	\$0 \$0.350,000M	\$0 CC 700 CCD AA		
PCP Office Visit	\$9,350 OOP Max	\$6,700 OOP Max		
Specialist Office Visit	\$0 Copay \$0 Copay	\$0 Copay		
		\$25 Copay		
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab) Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay and Authorization required \$0 Copay and Authorization required	\$0 Copay and Authorization required \$0 Copay and Authorization required		
X-rays	\$0 Copay and Authorization required	\$20 Copay and Authorization required		
Radiation Therapy	\$0 and Authorization required	\$175 Copay for Diagnostic \$60 for Therapeutic and Authorization required		
Preventive/Screening	\$0 and Authorization required \$0 Copay	\$175 Copay for Diagnostic \$60 for Therapeutic and Authorization required \$0 Copay		
Outpatient Physical and Speech Therapy	\$0 Copay and Authorization required	\$20 Copay and Authorization required		
Outpatient Mental Health	\$0 Copay for Individual and Group Sessions	\$25 Copay and Admonization required		
Outpatient Substance Abuse	\$0 Copay	\$25 Copay		
Medicare Covered Acupuncture	\$0 Copay and Authorization required	\$25 Copay and Authorization required		
Ambulatory Surgical Services	\$0 Copay and Authorization required	\$200 Copay and Authorization required		
Ambulance	\$0 Copay for Ground and Air. Authorization required for Non-Emergency Medicare Services	\$250 for Ground and Air. Authorization required for Non-Emergency Medicare Services		
Non-Emergency Medical Transportation	Transportation for medical needs (supplemental benefit) and transportation for non-medical	V250 for Ground and Am. Admonization required for Non-Emergency Medicare dervices		
	needs (VBID) are a combined limit of 76 one-way trips to plan approved locations. Mileage reimbursement is available when a personal car is used. Trip limit of 60 mile radius one way. Extra mileage up to 80 miles can be granted with prior approval based on plan limits for medical related trips only. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply.	30 one way trips to plan approved health related locations. Mileage reimbursement is available when a personal car is used. Trip limit of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted transportation vendor to receive service Scheduling rules and plan restrictions apply.		
Emergency Room	\$0 Copay	\$125 Copay will be waived if admitted to Hospital within 24 hours for the same condition and canno be applied towards Deductible		
Urgent Care	\$0 Copay	\$25 Copay		
Inpatient Hospital Stay (Acute and Psychiatric)	\$0 and Authorization required	\$250 Copay Days 1 – 6/\$0 Copay Days 7 – 90 and Authorization required		
Skilled Nursing Facility	\$0 and Authorization required	\$0 Copay Days 1 – 20/\$214 Copay Days 21 – 100 and Authorization required		
Home Health	\$0 and Authorization required	\$0 and Authorization required		
Diabetic Supplies and Services	\$0 Copay	\$0 Copay		
ОТС	\$263 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$263 allowance to pay plan approved utility expenses or to purches healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.	S82 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$50 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.		
Durable Medical Equipment	\$0 Copay and Authorization required	20% Coinsurance and Authorization required		
Meal Benefit	Beneficiary will be eligible for the benefit upon discharge from inpatient stay at hospital/rehab/ skilled nursing facility as monitored by the plan. Plan restrictions apply. Plan covers 28 meals over 14 days, no limit for the number of admissions.	Beneficiary will be eligible for the benefit upon discharge from inpatient stay at hospital/rehab/ skilled nursing facility as monitored by the plan. Plan restrictions apply. Plan covers 14 meals over seven days, no limit for the number of admissions.		
Fitness Benefit	Provides membership at participating network fitness centers at no cost	Provides membership at participating network fitness centers at no cost		
Home and Bathroom Safety Devices and Modifications	\$263 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$263 allowance to pay plan approved utility expenses or to purches healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.	S82 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$50 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.		
Personal Emergency Response System (PERS)	Benefit coordinated through Highmark Wholecare Health Case Manage	ement Department. Limited to one PERS device per member per lifetime.		
General Supports for Living	\$263 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$263 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.	\$82 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$50 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.		
Transportation for Non-Medical Needs	Non-medical trips are limited to 24 of the 76 combined trips. Non-medical trip radius is 30 miles.	N/A		
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient	Services covered with applicable Copay listed for outpatient		
Part B Drugs	\$0 Copay and Prior authorization required for certain prescription drugs	20% Coinsurance and Prior authorization required for certain prescription drugs		
Medicare Covered Vision (Office Visit)	\$0 Copay	\$0 Copay for diabetic retinal eye exam; \$25 Copay applies to all other Medicare-covered benefits		
Routine Vision (Office Visit)	\$0 Copay; One visit per year	\$0 Copay; One visit per year		
Routine Vision (Eyewear)	\$600 allowance toward eyeglass frames OR contacts. Limited to one pair of lenses and frames or contact lenses each year. The following lenses are covered in full: single vision, lined birds, lined trifocals, lenticular. The following lens upgrades are covered: Scratch coating, oversized lenses, Tints, Standard progressives, Photochromic lenses, UV coating, and Polycarbonate lenses. Plan restrictions apply.	\$200 allowance toward eyeglass frames OR contacts. Limited to one pair of lenses and frames or contact lenses each year. The following lenses are covered in full: single vision, lined bifocals, lined trifocals, lenticular. Plan restrictions apply.		
Medicare Covered Hearing Exam	\$0 Copay	\$25 Copay		
Routine Hearing Exam	\$0 Copay; One visit per year	\$0 Copay; One visit per year		
Routine Hearing (Hearing Aids) Routine Dental	\$0 Copay; Two Hearing Aids every year; TruHearing Advanced — \$0 Copay \$8,000 every year (combined with Comprehensive); One oral exam every six months; four cleanings every six months; Other X-ray includes: Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months.	\$0 Copay; Two Hearing Aids every three years; TruHearing Advanced — \$0 Copay 1 oral exam every six months; Four cleanings every six months; Other X-ray includes: Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months.		
Medicare Covered Comprehensive Dental	\$0 Copay; Authorization may be required for Medicare covered services	\$25 Minimum Copay and \$250 Maximum Copay; Authorization may be required for Medicare covered services		
Comprehensive Dental — Supplemental	\$8,000 every year (combined with Routine); Amalgam or resin fillings unlimited; Crowns limited to two per year, one crown in five years per tooth; Scaling and root planing limit four quads per visit with each quad once every year, full mouth debridement one per year, and any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year; simple extractions only; dentures are covered one per arch every year including a full denture, a partial denture routine for the denture of the properties.	\$3,500 every year; Amalgam or resin fillings unlimited; Crowns limited to one per year, one crown in five years per tooth. Scaling and root planing limit four quads per visit with each quad once every two years, full mouth debridement one per year, and any combination of routine prophylaxic and periodontal maintenance (D1110 and D4910) totaling four per year; Simple extractions only; dentures are covered one per arch every five years, including a full denture, a partial denture or a immediate denture and are not applied to the comprehensive maximum plan coverage amount		
Medicare Covered Chiropractic	\$0 Copay and Authorization required	\$15 Copay and Authorization required		
Routine Chiropractic	\$0 Copay and Authorization required	\$15 Copay and Authorization required		
Medicare Covered Podiatry	\$0 Copay	\$25 Copay		
Routine Podiatry	\$0 Copay	\$25 Copay		
Cardiac and Pulmonary Rehab and SET	\$0 Copay	\$0 Copay		
PART D DRUGS				
Part D Reduced Cost Sharing				
Cool straining trained for an an an energy decreased in Defining Products				

PRODUCTS AND PRICING BY COUNTY | D-SNP

Confidential and Proprietary — For Agent Use Only

New! Highmark Blue Cross Blue Shield Health Options Duals D-SNP



New! Highmark Blue Cross Blue Shield Health Options Duals D-SNP (Products and pricing by county)

	NEW HIGHMARK BUILT CROSS BUILT SUIFLD HEALTH ORTHONS BUALS
	NEW! HIGHMARK BLUE CROSS BLUE SHIELD HEALTH OPTIONS DUALS
Monthly Plan Premium	\$0
Out-of-Pocket Maximum	\$9,350 OOP Max
PCP Office Visit	\$0 Copay
Specialist Office Visit	\$0 Copay
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay and Authorization required
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay and Authorization required
X-rays	\$0 Copay and Authorization required
Radiation Therapy	\$0 Copay and Authorization required
Preventive/Screening	\$0 Copay
Outpatient Physical and Speech Therapy	\$0 Copay and Authorization required
Outpatient Mental Health	\$0 Coppy for Individual and Group Sessions
Outpatient Substance Abuse	\$0 Copay
Medicare Covered Acupuncture	\$0 Copay and Authorization required
Ambulatory Surgical Services	\$0 Coppy and Authorization required
Ambulance	\$0 Copay for Ground and Air. Authorization required for Non-Emergency Medicare Services
Non-Emergency Medical Transportation	Transportation for medical needs (supplemental benefit) and transportation for non-medical needs (VBID) are a combined limit of 36 one-way trips to plan
	approved locations. Mileage reimbursement is available when a personal car is used. Trip limit of 60 mile radius one way for medical trips and limit of 30 mile radius one way for non-medical trips. Extra mileage up to 80 miles can be granted with prior approval based on plan limits for medical related trips only. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply.
Emergency Room	\$0 Copay
Urgent Care	\$0 Copay
Inpatient Hospital Stay (Acute and Psychiatric)	\$0 and Authorization required
Skilled Nursing Facility	\$0 and Authorization required
Home Health	\$0 and Authorization required
Diabetic Supplies and Services	\$0 Copay
OTC	\$208 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$208 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.
Durable Medical Equipment	\$0 Copay and Authorization required
Meal Benefit	Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply. Plan covers 14 meals over 7 days, no limit for the number of admissions.
Fitness Benefit Home and Bathroom Safety Devices and Modifications	Plan provides a membership to a fitness and health platform that gives access to a nationwide network of gyms, local fitness studios, and community centers. This benefit also includes access to a digital library of at-home workouts and more. Members can access their benefit by creating an account and then selecting their fitness facility. Access to facilities in the participating network is unlimited. Members will also receive 32 credits each month of their enrollment for use at non-participating facilities. Members will be responsible for all fees that exceed their monthly credit balance. Unused credits will not roll over to the following month. Members can access their account online via mobile app or website. \$208 combined allowance for OTC, Food (WBID), Utility (VBID), and Home/Bathroom Safety.
,	Members can use the \$208 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select refail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will carry over from month to month. Any unused allowance will expire at the end of the calendar year. Fees and plan restrictions apply.
Personal Emergency Response System (PERS)	N/A
General Supports for Living	\$208 combined allowance for OTC, Food (VBID), Utility (VBID), and Home/Bathroom Safety. Members can use the \$208 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home and Bathroom Safety items via catalog. Unused allowances will expire at the end of the calendar year. Fees and plan restrictions apply.
Transportation for Non-Medical Needs	Transportation for medical needs (supplemental benefit) and transportation for non-medical needs (VBID) are a combined limit of 36 one-way trips to plan approved locations. Mileage reimbursement is available when a personal car is used. Trip limit of 60 mile radius one way for medical trips and limit of 30 mile radius one way for non-medical trips. Extra mileage up to 80 miles can be granted with prior approval based on plan limits for medical related trips only. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply.
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient
Part B Drugs	\$0 Copay and Prior authorization required for certain prescription drugs
Medicare Covered Vision (Office Visit)	\$0 Copay
Routine Vision (Office Visit)	\$0 Copay; One visit per year
Routine Vision (Eyewear)	\$400 allowance toward eyeglass frames OR contacts. Limited to one (1) pair of lenses and frames or contact lenses each year. The following lenses are covered in full: single vision, lined bifocals, lined trifocals, lent following lense upgrades are covered: Scratch coating, oversized lenses, Tints, Standard progressives, Photochromic lenses, UV coating, and Polycarbonate lenses. Plan restrictions apply.
Medicare Covered Hearing Exam	\$0 Copay
Routine Hearing Exam	\$0 Copay; One visit per year
Routine Hearing (Hearing Aids)	\$0 Copay; Two Hearing Aids every three years; TruHearing Advanced — \$0 Copay
Routine Dental	\$3,000 every year (combined with Comprehensive); 1 oral exam every six months; 4 cleanings per year; Other X-ray includes: Panoramic and full mouth X-rays
	once every 5 years, bitewing, periapical and occlusal X-rays once every 6 months.
Medicare Covered Comprehensive Dental	\$0 Copay; Authorization may be required for Medicare covered services
Comprehensive Dental — Supplemental	\$3,000 every year (combined with Routine); Amalgam or resin fillings unlimited; Crowns limited to 2 per year, 1 crown in 5 years per tooth; Scaling and root planing limit 4 quads per visit with each quad once every year, full mouth debridement one per year, and any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling 4 per year; simple extractions only; dentures are covered one per arch every year including a full denture, a partial denture or an immediate denture, and denture repairs
Medicare Covered Chiropractic	\$0 Copay and Authorization required
Routine Chiropractic	\$0 Copay and Authorization required
Medicare Covered Podiatry	\$0 Copay
Routine Podiatry	\$0 Copay
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 Copay
	PART D DRUGS
D 100 1 10 101 1	
Part D Reduced Cost Sharing	Cost sharing waived for all Part D drugs across all benefit phases

PRODUCTS AND PRICING BY COUNTY | D-SNP

Supplemental Benefits

Utility Support Benefit and Healthy Food Benefits

For 2025 there is a combined benefit that includes OTC, food, utilities and home/bathroom safety. The allowance has monthly rollover that expires at the end of the year.

Dental Benefit

Our plans give members an allowance for dental care including benefits like:

- Cleanings.
- Oral exams.
- X-rays.
- Crowns.
- Fillings.
- · Root canals.
- Annual coverage for dentures. (Annual coverage for dentures is limited to Diamond (PA) and Health Options Duals (DE) products. Ruby (PA) is once every five years.)

Vision Benefit

Members will receive an allowance for frames or contacts. Standard lens options are covered in full. Diamond and Health Options Dual members are eligible for select upgrades covered in full.

Hearing Benefit

We offer top-notch hearing benefits, including up to two TruHearing branded hearing aids every year for Diamond members and every three years for Ruby and Health Options Duals members. \$0 Copay for routine hearing exams and hearing aid fitting.

Over-The-Counter Benefit

Members can spend on Brand Name and Generic OTC products. This is included as part of the flex card benefit and is part of the combined monthly allowance.

Members can spend this allowance on products including:

- Cold and allergy medicine.
- Dental/denture hygiene.
- · Vitamins.
- · First aid supplies.
- Ointments.
- Incontinence products.
- Pain medication.

Transportation Benefit

All members receive free transportation to nonemergency medical appointments. Members can get free rides with a 60-mile radius to:

- Their doctor's office or other medical appointments.
- Their local pharmacy.
- Their local fitness center.
- · Other non-emergency medical appointments

Diamond and Health Options Duals plan members are eligible for non-emergency medical appointments and plan approved non-medical locations. Non-medical appointments are limited to a 30 mile trip radius. Medical trips have a 60 mile trip radius and may be eligible for extra mileage with prior plan approval.

Diamond members receive 76 one way trips; up to 24 one way trips can be used for non-medical locations. Health Options Duals members receive a combined 36 one way trips for medical or non-medical locations.

Every Ruby plan member receives 30 one-way trips to non-emergency medical locations.

FitOn

This benefit provides in-person access to fitness and wellness classes at health clubs across the country and virtual classes online at no cost. Members can get fit, make friends, and live a healthier, more active life with this program. The benefit provides access to over 13,000 fitness facilities and community centers with cardio and weight equipment, pools, saunas, and exercise classes.

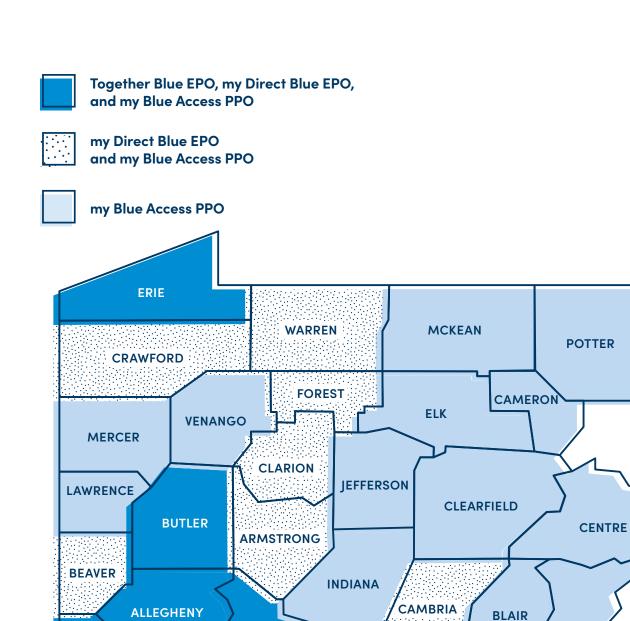
Members receive 32 credits each month to use towards memberships/classes at these gyms and fitness facilities. They will be responsible for all fees that exceed the monthly credit balance. Unused credits will not roll over to the following month.

Members must create an account online, via mobile app, or website and then select the fitness facility. They may also contact Member Service for assistance in creating an account. The website and app provides Hollywood production quality fitness classes, custom meal planning, condition-specific courses, and an online community. Call **1-855-946-4036** to take advantage of this valuable program.

PRODUCTS AND PRICING BY COUNTY

ACA Individual Market

WPA



WESTMORELAND

FAYETTE

SOMERSET

HUNTINGDON

BEDFORD

WASHINGTON

GREENE

WPA, cont.

Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Bronze 7400 HSA — Custom Drug Benefit	Bronze 3800
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$3,800 Family: \$7,600
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0*	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$65 copay X-ray: \$150 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0 after deductible	\$0 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible	Tier 1 drugs: \$15* All other tiers: 50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

^{*}Not subject to deductible

WPA, cont.

Coverage Level	Silver 7000	Premier Silver 0	Silver 3500 Off Exchange Only	Gold 0
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$0 Family: \$0	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,350 Family: \$16,700	Individual: \$9,200 Family: \$18,400	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$70 copay	\$70 copay	\$50 copay	\$20 copay
Specialist Visit	\$70 copay	\$70 copay	\$50 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$70 copay	\$70 copay	\$50 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$70 copay	\$70 copay	\$50 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$90 copay	\$70 copay	\$55 copay	\$35 copay
Urgent Care	\$100 copay	\$100 copay	\$100 copay	\$40 copay
Emergency Services	\$750 copay after deductible	\$1,250 copay	30% after deductible	\$300 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	\$2,500 copay	30% after deductible	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

WPA, cont.

Coverage Level	Premier Gold 0	Gold 1500	Gold 1700 HSA	Premier Platinum 0
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400	Individual: \$5,000 Family: \$10,000
Primary Care Visit	\$15 copay	\$35 copay	\$20 copay after deductible	\$0 copay
Specialist Visit	\$15 copay	\$35 copay	\$20 copay after deductible	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 copay after deductible	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 copay after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	\$35 copay	\$40 copay	\$20 copay after deductible	\$0 copay
Urgent Care	\$30 copay	\$70 copay	\$40 copay after deductible	\$5 copay
Emergency Services	\$280 copay	\$350 copay	\$175 copay after deductible	\$100 copay
Hospital Inpatient (per visit)	\$525 copay	\$725 copay after deductible	\$450 copay after deductible	\$325 copay
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0 after deductible/ \$30 after deductible/ \$150 after deductible/ 50% after deductible	\$0/\$25/\$75/50%
Adult Dental and Vision Available	Yes	No	No	Yes

WPA — Extra Savings

Income Level	200 – 249% FPL		150 – 99% FPL	
Coverage Level	Extra Savings Silver 3700	Premier Extra Savings Silver 0	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,800 Family: \$13,600	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Specialist Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$70 copay	\$15 copay	\$15 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	\$70 copay	\$25 copay	\$60 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 copay after deductible	\$1,250 copay	\$375 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	\$2,500 copay	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

WPA — Extra Savings

Income Level	138 – 149% FPL	
Coverage Level	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	\$1 copay	\$0 copay
Specialist Visit	\$1 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$1 copay	\$0 copay
Urgent Care	\$5 copay	\$5 copay
Emergency Services	\$75 copay	\$75 copay
Hospital Inpatient (per visit)	\$175 copay	\$175 copay
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%
Adult Dental and Vision Available	No	Yes

CPA



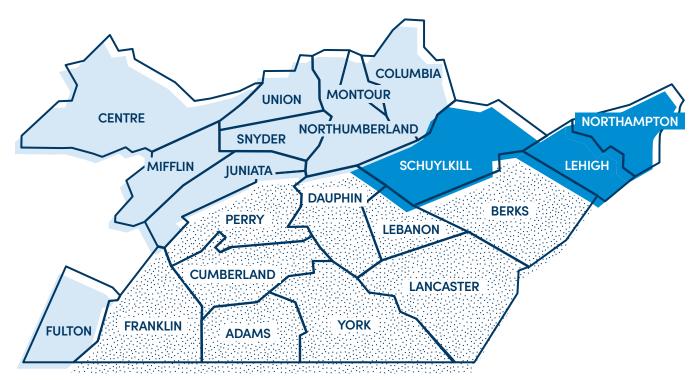
my Direct Blue Lehigh Valley EPO and my Blue Access PPO



my Direct Blue EPO and my Blue Access PPO



my Blue Access PPO



CPA, cont.

Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Bronze 7400 HSA — Custom Drug Benefit	Bronze 3800
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$3,800 Family: \$7,600
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0*	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$65 copay X-ray: \$150 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0 after deductible	\$0 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible	Tier 1 drugs: \$15* All other tiers: 50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

^{*}Not subject to deductible

CPA, cont.

Coverage Level	Silver 7000	Silver 3500 (Off Exchange only)	Premier Silver 0	Gold 0
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$8,350 Family: \$16,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Specialist Visit	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$90 copay	\$55 copay	\$70 copay	\$35 copay
Urgent Care	\$100 copay	\$100 copay	\$100 copay	\$40 copay
Emergency Services	\$750 copay after deductible	30% after deductible	\$1,250 copay	\$300 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	30% after deductible	\$2,500 copay	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

CPA, cont.

Coverage Level	Premier Gold 0	Gold 1500	Gold 1700 HSA
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In-Network out-of- pocket maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15 copay	\$35 copay	\$20 copay after deductible
Specialist Visit	\$15 copay	\$35 copay	\$20 copay after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 copay after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 copay after deductible
Diagnostic Test (Lab/X-ray)	\$35 copay	\$40 copay	\$20 copay after deductible
Urgent Care	\$30 copay	\$70 copay	\$40 copay after deductible
Emergency Services	\$280 copay	\$350 copay	\$175 copay after deductible
Hospital Inpatient (per visit)	\$525 copay	\$725 copay after deductible	\$450 copay after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0 after deductible/ \$30 after deductible/ \$150 after deductible/ 50% after deductible
Adult Dental and Vision Available	Yes	No	No

CPA — Extra Savings

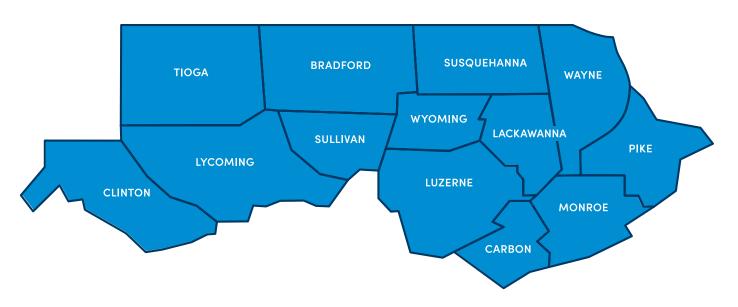
Income Level	200 – 249% FPL		150 – 199% FPL	
Coverage Level	Extra Savings Silver 3700	Premier Extra Savings Silver 0	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,800 Family: \$13,600	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Specialist Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$70 copay	\$15 copay	\$15 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	\$70 copay	\$25 copay	\$60 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 copay after deductible	\$1,250 copay	\$375 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	\$2,500 copay	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

CPA — Extra Savings

Income Level	138 – 149% FPL		
Coverage Level	Extra Savings Silver 0	Premier Extra Savings Silver 0	
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400	
Primary Care Visit	\$1 copay	\$0 copay	
Specialist Visit	\$1 copay	\$0 copay	
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$1 copay	\$0 copay	
Urgent Care	\$5 copay	\$5 copay	
Emergency Services	\$75 copay	\$75 copay	
Hospital Inpatient (per visit)	\$175 copay	\$175 copay	
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%	
Adult Dental and Vision Available	No	Yes	

NEPA





Coverage Level	Catastrophic 9200 —	Bronze	Bronze 7400 HSA —	Bronze
	3 Free PCP Visits	8900	Custom Drug Benefit	3800
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network	Individual: \$9,200	Individual: \$8,900	Individual: \$7,400	Individual: \$3,800
Deductible	Family: \$18,400	Family: \$17,800	Family: \$14,800	Family: \$7,600
In-Network out-of-	Individual: \$9,200	Individual: \$8,900	Individual: \$7,400	Individual: \$9,200
pocket maximum	Family: \$18,400	Family: \$17,800	Family: \$14,800	Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$65 copay Standard: \$80 copay
Specialist Visit	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$65 copay Standard: \$80 copay

NEPA, cont.

Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Bronze 7400 HSA — Custom Drug Benefit	Bronze 3800
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$65 copay Standard: \$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$65 copay Standard: \$80 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Lab: Enhanced: \$65 copay, Standard: \$95 copay X-ray: Enhanced: \$150 copay, Standard: \$160 copay
Urgent Care	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$100 copay Standard: \$100 copay
Emergency Services	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: 50% after deductible Standard: 50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Enhanced: 50% after deductible Standard: 60% after deductible
Pharmacy Summary	\$0 after deductible	Enhanced: \$0 after deductible Standard: \$0 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible	Enhanced: Tier 1 drugs: \$15* All other tiers: 50% after deductible Standard: Tier 1 drugs: \$15* All other tiers: 50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

^{*}Not subject to deductible

NEPA, cont.

Coverage Level	Silver	Silver 3500	Premier	Gold
	7000	(Off Exchange only)	Silver 0	0
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network	Individual: \$7,000	Individual: \$3,500	Individual: \$0	Individual: \$0
Deductible	Family: \$14,000	Family: \$7,000	Family: \$0	Family: \$0
In-Network out-of-	Individual: \$9,200	Individual: \$9,200	Individual: \$8,350	Individual: \$7,500
pocket maximum	Family: \$18,400	Family: \$18,400	Family: \$16,700	Family: \$15,000
Primary Care Visit	Enhanced: \$70 copay	Enhanced: \$50 copay	Enhanced: \$70 copay	Enhanced: \$20 copay
	Standard: \$75 copay	Standard: \$70 copay	Standard: \$90 copay	Standard: \$30 copay
Specialist Visit	Enhanced: \$70 copay	Enhanced: \$50 copay	Enhanced: \$70 copay	Enhanced: \$20 copay
	Standard: \$75 copay	Standard: \$70 copay	Standard: \$90 copay	Standard: \$30 copay
Outpatient Mental Health/Substance Abuse Visits	Enhanced: \$70 copay Standard: \$70 copay	Enhanced: \$50 copay Standard: \$50 copay	Enhanced: \$70 copay Standard: \$70 copay	Enhanced: \$20 copay Standard: \$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	Enhanced: \$70 copay Standard: \$75 copay	Enhanced: \$50 copay Standard: \$70 copay	Enhanced: \$70 copay Standard: \$90 copay	Enhanced: \$20 copay Standard: \$30 copay
Diagnostic Test	Enhanced: \$75 copay	Enhanced: \$55 copay	Enhanced: \$70 copay	Enhanced: \$35 copay
(Lab/X-ray)	Standard: \$85 copay	Standard: \$75 copay	Standard: \$90 copay	Standard: \$50 copay
Urgent Care	Enhanced: \$100 copay	Enhanced: \$100 copay	Enhanced: \$100 copay	Enhanced: \$40 copay
	Standard: \$100 copay	Standard: \$100 copay	Standard: \$100 copay	Standard: \$40 copay
Emergency Services	Enhanced: \$750 copay after deductible Standard: \$750 copay after deductible	Enhanced: 30% after deductible Standard: 30% after deductible	Enhanced: \$1,250 copay Standard: \$1,250 copay	Enhanced: \$300 copay Standard: \$300 copay
Hospital Inpatient (per visit)	Enhanced: \$1,125 copay after deductible Standard: \$1,375 copay after deductible	Enhanced: 30% after deductible Standard: 50% after deductible	Enhanced: \$2,500 copay Standard: \$3,000 copay	Enhanced: \$725 copay Standard: \$875 copay
Pharmacy Summary	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

NEPA, cont.

Coverage Level	Premier	Gold	Gold
	Gold 0	1500	1700 HSA
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network	Individual: \$0	Individual: \$1,500	Individual: \$1,700
Deductible	Family: \$0	Family: \$3,000	Family: \$3,400
In-Network out-of-	Individual: \$6,550	Individual: \$8,300	Individual: \$5,700
pocket maximum	Family: \$13,100	Family: \$16,600	Family: \$11,400
Primary Care Visit	Enhanced: \$15 copay	Enhanced: \$35 copay	Enhanced: \$20 copay after deductible
	Standard: \$25 copay	Standard: \$40 copay	Standard: \$25 copay after deductible
Specialist Visit	Enhanced: \$15 copay	Enhanced: \$35 copay	Enhanced: \$20 copay after deductible
	Standard: \$25 copay	Standard: \$40 copay	Standard: \$25 copay after deductible
Outpatient Mental Health/Substance Abuse Visits	Enhanced: \$15 copay Standard: \$15 copay	Enhanced: \$35 copay Standard: \$35 copay	Enhanced: \$20 copay after deductible Standard: \$20 copay after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	Enhanced: \$40 copay Standard: \$50 copay	Enhanced: \$35 copay Standard: \$40 copay	Enhanced: \$20 copay after deductible Standard: \$25 copay after deductible
Diagnostic Test	Enhanced: \$35 copay	Enhanced: \$40 copay	Enhanced: \$20 copay after deductible
(Lab/X-ray)	Standard: \$50 copay	Standard: \$50 copay	Standard: \$25 copay after deductible
Urgent Care	Enhanced: \$30 copay	Enhanced: \$70 copay	Enhanced: \$40 copay after deductible
	Standard: \$30 copay	Standard: \$70 copay	Standard: \$40 copay after deductible
Emergency Services	Enhanced: \$280 copay	Enhanced: \$350 copay	\$175 copay after deductible
	Standard: \$280 copay	Standard: \$350 copay	Standard: \$175 copay after deductible
Hospital Inpatient (per visit)	Enhanced: \$525 copay Standard: \$650 copay	Enhanced: \$725 copay after deductible Standard: \$875 copay after deductible	Enhanced: \$450 copay after deductible Standard: \$550 copay after deductible
Pharmacy Summary	Enhanced: \$0/\$25/\$75/50% Standard: \$0/\$25/\$75/50%	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0 after deductible/\$30 after deductible/ \$150 after deductible/50% after deductible Standard: \$0 after deductible/\$30 after deductible/ \$150 after deductible/50% after deductible
Adult Dental and Vision Available	Yes	No	No

NEPA — Extra Savings

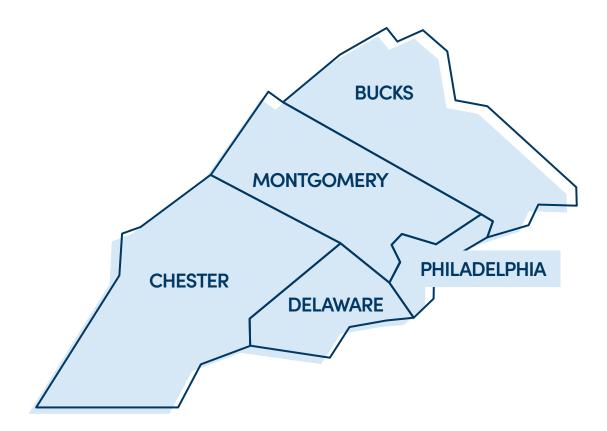
Income Level	200 – 249% FPL		150 – 199% FPL	
Coverage Level	Extra Savings Silver 3700	Premier Extra Savings Silver 0	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,800 Family: \$13,600	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	Enhanced: \$65 copay Standard: \$75 copay	Enhanced: \$70 copay Standard: \$90 copay	Enhanced: \$15 copay Standard: \$25 copay	Enhanced: \$0 copay Standard: \$15 copay
Specialist Visit	Enhanced: \$65 copay Standard: \$75 copay	Enhanced: \$70 copay Standard: \$90 copay	Enhanced: \$15 copay Standard: \$25 copay	Enhanced: \$0 copay Standard: \$15 copay
Outpatient Mental Health/Substance Abuse Visits	Enhanced: \$65 copay Standard: \$65 copay	Enhanced: \$70 copay Standard: \$70 copay	Enhanced: \$15 copay Standard: \$15 copay	Enhanced: \$0 copay Standard: \$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	Enhanced: \$65 copay Standard: \$75 copay	Enhanced: \$70 copay Standard: \$90 copay	Enhanced: \$15 copay Standard: \$30 copay	Enhanced: \$15 copay Standard: \$30 copay
Diagnostic Test (Lab/X-ray)	Enhanced: \$65 copay Standard: \$75 copay	Enhanced: \$70 copay Standard: \$90 copay	Enhanced: \$25 copay Standard: \$35 copay	Enhanced: \$60 copay Standard: \$80 copay
Urgent Care	Enhanced: \$100 copay Standard: \$100 copay	Enhanced: \$100 copay Standard: \$100 copay	Enhanced: \$30 copay Standard: \$30 copay	Enhanced: \$10 copay Standard: \$10 copay
Emergency Services	Enhanced: \$750 copay after deductible Standard: \$750 copay after deductible	Enhanced: \$1,250 copay Standard: \$1,250 copay	Enhanced: \$375 copay Standard: \$375 copay	Enhanced: \$500 copay Standard: \$500 copay
Hospital Inpatient (per visit)	Enhanced: \$1,125 copay after deductible Standard: \$1,375 copay after deductible	Enhanced: \$2,500 copay Standard: \$3,000 copay	Enhanced: \$450 copay Standard: \$575 copay	Enhanced: \$450 copay Standard: \$575 copay
Pharmacy Summary	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0/\$30/\$150/50% Standard: \$0/\$30/\$150/50%	Enhanced: \$0/\$10/\$50/50% Standard: \$0/\$10/\$50/50%	Enhanced: \$0/\$10/\$50/50% Standard: \$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

NEPA — Extra Savings

Income Level	138 – 149% FPL	
Coverage Level	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	Enhanced: \$1 copay Standard: \$5 copay	Enhanced: \$0 copay Standard: \$5 copay
Specialist Visit	Enhanced: \$1 copay Standard: \$5 copay	Enhanced: \$0 copay Standard: \$5 copay
Outpatient Mental Health/Substance Abuse Visits	Enhanced: \$1 copay Standard: \$5 copay	Enhanced: \$0 copay Standard: \$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	Enhanced: \$1 copay Standard: \$5 copay	Enhanced: \$0 copay Standard: \$5 copay
Diagnostic Test (Lab/X-ray)	Enhanced: \$1 copay Standard: \$5 copay	Enhanced: \$0 copay Standard: \$5 copay
Urgent Care	Enhanced: \$5 copay Standard: \$5 copay	Enhanced: \$5 copay Standard: \$5 copay
Emergency Services	Enhanced: \$75 copay Standard: \$75 copay	Enhanced: \$75 copay Standard: \$75 copay
Hospital Inpatient (per visit)	Enhanced: \$175 copay Standard: \$215 copay	Enhanced: \$175 copay Standard: \$215 copay
Pharmacy Summary	Enhanced: \$0/\$5/\$15/50% Standard: \$0/\$5/\$15/50%	Enhanced: \$0/\$5/\$15/50% Standard: \$0/\$5/\$15/50%
Adult Dental and Vision Available	No	Yes

SEPA

my Blue Access PPO



SEPA, cont.

Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Bronze 7400 HSA — Custom Drug Benefit	Bronze 3800
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$3,800 Family: \$7,600
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,400 Family: \$14,800	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0*	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray) Member Savings Site/Non- Member Savings Site	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$55/\$105 copay X-ray: \$125/250 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0 after deductible	\$0 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible	Tier 1 drugs: \$15* All other tiers: 50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

^{*}Not subject to deductible

SEPA, cont.

Coverage Level	Silver 7000	Silver 3500 (Off Exchange only)	Premier Silver 0	Gold 0
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network out–of– pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$8,350 Family: \$16,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Specialist Visit	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$70 copay	\$50 copay	\$70 copay	\$20 copay
Diagnostic Test (Lab/X-ray) Member Savings Site/Non- Member Savings Site	\$80/\$130 copay	\$50/\$75 copay	\$65/\$90 copay	\$30/\$55 copay
Urgent Care	\$100 copay	\$100 copay	\$100 copay	\$40 copay
Emergency Services	\$750 copay after deductible	30% after deductible	\$1,250 copay	\$300 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	30% after deductible	\$2,500 copay	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

SEPA, cont.

Coverage Level	Premier Gold 0	Gold 1500	Gold 1700 HSA
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In-Network out-of- pocket maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15 copay	\$35 copay	\$20 copay after deductible
Specialist Visit	\$15 copay	\$35 copay	\$20 copay after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 copay after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 copay after deductible
Diagnostic Test (Lab/X-ray) Member Savings Site/Non- Member Savings Site	\$30/\$55 copay	\$35/\$60 copay	\$20 copay after deductible
Urgent Care	\$30 copay	\$70 copay	\$40 copay after deductible
Emergency Services	\$280 copay	\$350 copay	\$175 copay after deductible
Hospital Inpatient (per visit)	\$525 copay	\$725 copay after deductible	\$450 copay after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0 after deductible/ \$30 after deductible/ \$150 after deductible/ 50% after deductible
Adult Dental and Vision Available	Yes	No	No

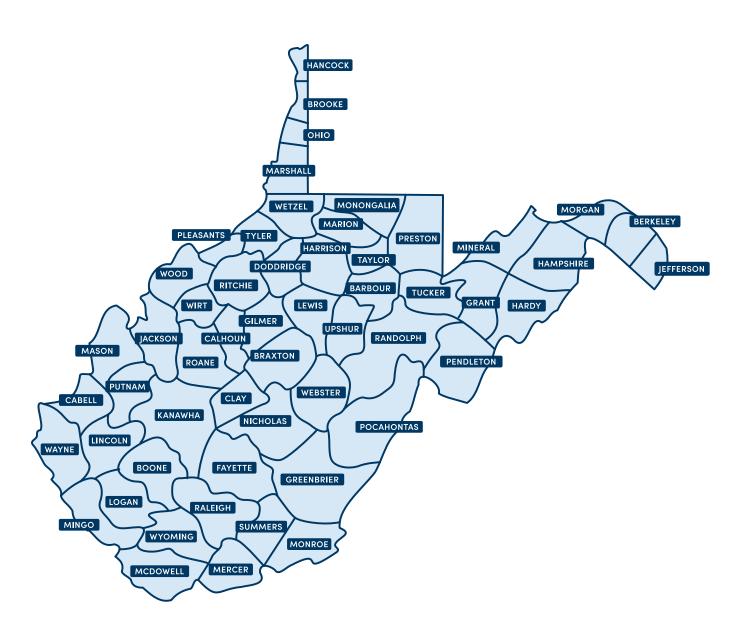
SEPA — Extra Savings

Income Level	200 – 249% FPL		150 – 199% FPL	
Coverage Level	Extra Savings Silver 3700	Premier Extra Savings Silver 0	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,800 Family: \$13,600	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Specialist Visit	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$70 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$70 copay	\$15 copay	\$15 copay
Diagnostic Test (Lab/X-ray) Member Savings Site/Non- Member Savings Site	\$60/\$85 copay	\$65/\$90 copay	\$20/\$45 copay	\$55/\$80 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 copay after deductible	\$1,250 copay	\$375 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 copay after deductible	\$2,500 copay	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

SEPA — Extra Savings

Income Level	138 – 149% FPL	
Coverage Level	Extra Savings Silver 0	Premier Extra Savings Silver 0
Plan Availability	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	\$1 copay	\$0 copay
Specialist Visit	\$1 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay
Diagnostic Test (Lab/X-ray) Member Savings Site/Non- Member Savings Site	\$0/\$5 copay	\$0 copay
Urgent Care	\$5 copay	\$5 copay
Emergency Services	\$75 copay	\$75 copay
Hospital Inpatient (per visit)	\$175 copay	\$175 copay
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%
Adult Dental and Vision Available	No	Yes

WV



WV, cont.

Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Standard Bronze 7500	Bronze 7400 HSA — Custom Drug Benefit
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,500 Family: \$15,000	Individual: \$7,400 Family: \$14,800
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$9,200 Family: \$18,400	Individual: \$7,400 Family: \$14,800
Primary Care Visit	\$0 after deductible; First three visits \$0*	\$0 after deductible	\$50 copay	\$0 after deductible
Specialist Visit	\$0 after deductible	\$0 after deductible	\$100 copay	\$0 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Urgent Care	\$0 after deductible	\$0 after deductible	\$75 copay	\$0 after deductible
Emergency Services	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Pharmacy Summary	\$0 after deductible	\$0 after deductible	\$25*/ \$50 after deductible/ \$100 after deductible/ \$500 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible
Adult Dental and Vision Available	No	No	No	No

^{*}Not subject to deductible

WV, cont.

Coverage Level	Bronze 3800	Silver 7000	Standard Silver 5000	Silver 3500 (Off Exchange only)
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$7,000 Family: \$14,000	Individual: \$5,000 Family: \$10,000	Individual: \$3,500 Family: \$7,000
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$8,000 Family: \$16,000	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$65 copay	\$70 copay	\$40 copay	\$50 copay
Specialist Visit	\$65 copay	\$70 copay	\$80 copay	\$50 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$70 copay	\$40 copay	\$50 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$70 copay	\$40 copay	\$50 copay
Diagnostic Test (Lab/X-ray)	Lab: \$65 copay X-ray: \$150 copay	\$90 copay	40% after deductible	\$55 copay
Urgent Care	\$100 copay	\$100 copay	\$60 copay	\$100 copay
Emergency Services	50% after deductible	\$750 after deductible	40% after deductible	40% after deductible
Hospital Inpatient (per visit)	50% after deductible	\$1,125 copay after deductible	40% after deductible	40% after deductible
Pharmacy Summary	Tier 1 drugs: \$15* All other tiers: 50% after deductible	\$0/\$30/\$150/50%	\$20*/\$40*/ \$80 after deductible/ \$350 after deductible	\$0/\$50/\$225/50%
Adult Dental and Vision Available	Yes	No	Yes	Yes

^{*}Not subject to deductible

WV, cont.

Coverage Level	Standard Gold 1500	Gold 0	Premier Gold 0	Gold 1700 HSA
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$1,500 Family: \$3,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$1,700 Family: \$3,400
In-Network out-of- pocket maximum	Individual: \$7,800 Family: \$15,600	Individual: \$7,500 Family: \$15,000	Individual: \$6,700 Family: \$13,400	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$30 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Specialist Visit	\$60 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Outpatient Mental Health/Substance Abuse Visits	\$30 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Diagnostic Test (Lab/X-ray)	25% after deductible	\$35 copay	\$50 copay	\$20 copay after deductible
Urgent Care	\$45 copay	\$40 copay	\$30 copay	\$40 copay after deductible
Emergency Services	25% after deductible	\$300 copay	\$280 copay	\$175 copay after deductible
Hospital Inpatient (per visit)	25% after deductible	\$725 copay	\$525 copay	\$450 copay after deductible
Pharmacy Summary	\$15/\$30/\$60/\$250	\$0/\$30/\$150/50%	\$0/\$25/\$75/50%	\$0 after deductible/ \$30 after deductible/ \$150 after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	Yes	No

WV — Extra Savings

Income Level	200 – 249% FPL		150 – 199% FPL	
Coverage Level	Extra Savings Silver 3700	Standard Extra Savings Silver 3000	Extra Savings Silver 0	Standard Extra Savings Silver 500
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$3,000 Family: \$6,000	Individual: \$0 Family: \$0	Individual: \$500 Family: \$1,000
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,400 Family: \$12,800	Individual: \$3,050 Family: \$6,100	Individual: \$3,000 Family: \$6,000
Primary Care Visit	\$65 copay	\$40 copay	\$15 copay	\$20 copay
Specialist Visit	\$65 copay	\$80 copay	\$15 copay	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$40 copay	\$15 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$40 copay	\$15 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	40% after deductible	\$25 copay	30% after deductible
Urgent Care	\$100 copay	\$60 copay	\$30 copay	\$30 copay
Emergency Services	\$750 after deductible	40% after deductible	\$375 copay	30% after deductible
Hospital Inpatient (per visit)	\$1,125 copay after deductible	40% after deductible	\$450 copay	30% after deductible
Pharmacy Summary	\$0/\$30/\$150/50%	\$20*/\$40*/ \$80 after deductible/ \$350 after deductible	\$0/\$10/\$50/50%	\$10*/\$20*/ \$60 after deductible/ \$250 after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

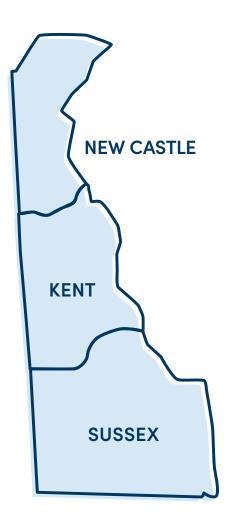
^{*}Not subject to deductible

WV — Extra Savings

Income Level	138 – 149% FPL		
Coverage Level	Extra Savings Silver 0	Standard Extra Savings Silver 0	
Plan Availability	my Blue Access PPO	my Blue Access PPO	
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$2,000 Family: \$4,000	
Primary Care Visit	\$1 copay	\$0 copay	
Specialist Visit	\$1 copay	\$10 copay	
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$1 copay	25%	
Urgent Care	\$5 copay	\$5 copay	
Emergency Services	\$75 copay	25%	
Hospital Inpatient (per visit)	\$175 copay	25%	
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$15/\$50/\$150	
Adult Dental and Vision Available	No	Yes	

DE





Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Standard Bronze 7500	Bronze 7400 HSA — Custom Drug Benefit
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$7,500 Family: \$15,000	Individual: \$7,400 Family: \$14,800
In–Network out–of– pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$8,900 Family: \$17,800	Individual: \$9,200 Family: \$18,400	Individual: \$7,400 Family: \$14,800
Primary Care Visit	\$0 after deductible; First three visits \$0*	\$0 after deductible	\$50 copay	\$0 after deductible
Specialist Visit	\$0 after deductible	\$0 after deductible	\$100 copay	\$0 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$23 copay	\$0 after deductible
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Urgent Care	\$0 after deductible	\$0 after deductible	\$75 copay	\$0 after deductible
Emergency Services	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Pharmacy Summary	\$0 after deductible	\$0 after deductible	\$25*/ \$50 after deductible/ \$100 after deductible/ \$150 after deductible	Select Rx: \$0* All other Rx: \$0 after deductible
Adult Dental and Vision Available	No	No	No	No

^{*}Not subject to deductible

Coverage Level	Bronze 3800	Silver 7000	Standard Silver 5000	Silver 3500 (Off Exchange only)
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$7,000 Family: \$14,000	Individual: \$5,000 Family: \$10,000	Individual: \$3,500 Family: \$7,000
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$8,000 Family: \$16,000	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$70 copay	\$70 copay	\$40 copay	\$50 copay
Specialist Visit	\$70 copay	\$70 copay	\$80 copay	\$50 copay
Outpatient Mental Health/Substance Abuse Visits	\$70 copay	\$70 copay	\$40 copay	\$50 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$23 copay	\$23 copay	\$23 copay	\$23 copay
Diagnostic Test (Lab/X-ray)	Lab: \$65 copay X-ray: \$150 copay	\$90 copay	40% after deductible	\$70 copay
Urgent Care	\$100 copay	\$100 copay	\$60 copay	\$100 copay
Emergency Services	50% after deductible	\$750 copay after deductible	40% after deductible	40% after deductible
Hospital Inpatient (per visit)	50% after deductible	\$1,125 copay after deductible	40% after deductible	40% after deductible
Pharmacy Summary	Tier 1 drugs: \$15* All other tiers: 50% after deductible	\$0/\$30/\$150/50%	\$20*/\$40*/ \$80 after deductible/ \$125 after deductible	\$0/\$50/\$225/50%
Adult Dental and Vision Available	Yes	No	Yes	Yes

^{*}Not subject to deductible

Coverage Level	Standard Gold 1500	Gold 0	Premier Gold 0	Gold 1700 HSA
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$1,500 Family: \$3,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$1,700 Family: \$3,400
In-Network out-of- pocket maximum	Individual: \$7,800 Family: \$15,600	Individual: \$7,500 Family: \$15,000	Individual: \$6,700 Family: \$13,400	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$30 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Specialist Visit	\$60 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Outpatient Mental Health/Substance Abuse Visits	\$30 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$23 copay	\$20 copay	\$15 copay	\$20 copay after deductible
Diagnostic Test (Lab/X-ray)	25% after deductible	\$35 copay	\$50 copay	\$20 copay after deductible
Urgent Care	\$45 copay	\$40 copay	\$30 copay	\$40 copay after deductible
Emergency Services	25% after deductible	\$300 copay	\$280 copay	\$175 copay after deductible
Hospital Inpatient (per visit)	25% after deductible	\$725 copay	\$525 copay	\$450 copay after deductible
Pharmacy Summary	\$15/\$30/\$60/\$100	\$0/\$30/\$150/50%	\$0/\$25/\$75/50%	\$0 after deductible/ \$30 after deductible/ \$150 after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	Yes	No

Coverage Level	Standard Platinum 0	Premier Platinum 0
Plan Availability	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$4,300 Family: \$8,600	Individual: \$5,000 Family: \$10,000
Primary Care Visit	\$10 copay	\$0 copay
Specialist Visit	\$20 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$10 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$30 copay	\$0 copay
Urgent Care	\$15 copay	\$5 copay
Emergency Services	\$100 copay	\$100 copay
Hospital Inpatient (per visit)	\$350 copay	\$325 copay
Pharmacy Summary	\$5/\$10/\$50/\$75	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes

DE — Extra Savings

Income Level	200 – 249% FPL		150 – 199% FPL	
Coverage Level	Extra Savings Silver 3700	Standard Extra Savings Silver 3000	Extra Savings Silver 0	Standard Extra Savings Silver 500
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$3,000 Family: \$6,000	Individual: \$0 Family: \$0	Individual: \$500 Family: \$1,000
In-Network out-of- pocket maximum	Individual: \$7,200 Family: \$14,400	Individual: \$6,400 Family: \$12,800	Individual: \$3,050 Family: \$6,100	Individual: \$3,000 Family: \$6,000
Primary Care Visit	\$70 copay	\$40 copay	\$15 copay	\$20 copay
Specialist Visit	\$70 copay	\$80 copay	\$15 copay	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$70 copay	\$40 copay	\$15 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$23 copay	\$23 copay	\$15 copay	\$20 copay
Chiropractic Care	25% after deductible	25% after deductible	10%	25% after deductible
Diagnostic Test (Lab/X-ray)	\$65 copay	40% after deductible	\$25 copay	30% after deductible
Urgent Care	\$100 copay	\$60 copay	\$30 copay	\$30 copay
Emergency Services	\$750 copay after deductible	40% after deductible	\$375 copay	30% after deductible
Hospital Inpatient (per visit)	\$1,125 copay after deductible	40% after deductible	\$450 copay	30% after deductible
Pharmacy Summary	\$0/\$30/\$150/50%	\$20*/\$40*/ \$80 after deductible/ \$125 after deductible	\$0/\$10/\$50/50%	\$10*/\$20*/ \$60 after deductible/ \$100 after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

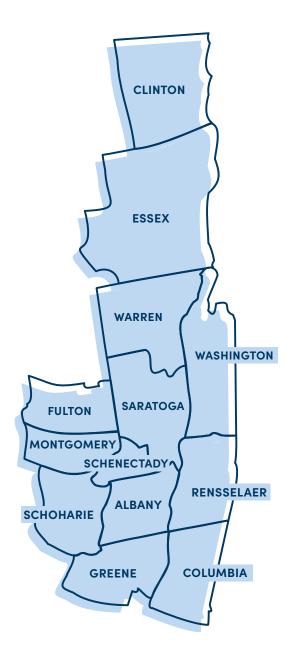
^{*}Not subject to deductible

DE — Extra Savings

Income Level	138 – 149% FPL	
Coverage Level	Extra Savings Silver 0	Standard Extra Savings Silver 0
Plan Availability	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	\$1 copay	\$0 copay
Specialist Visit	\$1 copay	\$10 copay
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay
Chiropractic Care	10%	25%
Diagnostic Test (Lab/X-ray)	\$1 copay	25%
Urgent Care	\$5 copay	\$5 copay
Emergency Services	\$75 copay	25%
Hospital Inpatient (per visit)	\$175 copay	25%
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$10/\$20
Adult Dental and Vision Available	No	Yes

NENY

my Blue Access EX



NENY, cont.

Coverage Level	Bronze Standard	Bronze Destination 65	Silver Standard	Silver Destination 65
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$3,800 Family: \$7,600	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$50 copay after deductible	\$75 copay	\$30 copay after deductible	\$0 copay
Specialist Visit	\$75 copay after deductible	\$75 copay	\$65 copay after deductible	\$50 copay
Outpatient Mental Health/Substance Abuse Visits	\$50 copay after deductible	\$75 copay	\$30 copay after deductible	\$0 copay
Speech, Physical, and Occupational Therapy	\$50 copay after deductible	\$75 copay	\$30 copay after deductible	\$50 copay
Chiropractic Care	\$75 copay after deductible	\$75 copay	\$65 copay after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	Lab: \$50 copay after deductible X-ray: \$75 copay after deductible	Lab: \$75 copay X-ray: \$155 copay	Lab: \$50 copay after deductible X-ray: \$75 copay after deductible	Lab: \$40 copay X-ray: \$150 copay
Urgent Care	\$75 copay after deductible	\$100 copay	\$70 copay after deductible	\$100 copay
Emergency Services	\$500 copay after deductible	50% after deductible	\$500 copay after deductible	\$1,000 copay
Hospital Inpatient (per visit)	\$1,500 copay after deductible	50% after deductible	\$1,500 copay after deductible	\$2,000 copay
Pharmacy Summary	\$10 after deductible/ \$35 after deductible/ \$70 after deductible	\$25*/ 50% after deductible/ 50% after deductible	\$15/\$40/\$75	\$15 after deductible/ 50% after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

^{*}Not subject to deductible

NENY, cont.

Coverage Level	Gold Standard	Gold Destination 65	Platinum Standard	Platinum Destination 65
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$600 Family: \$1,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,900 Family: \$15,800	Individual: \$7,500 Family: \$15,000	Individual: \$2,000 Family: \$4,000	Individual: \$5,000 Family: \$10,000
Primary Care Visit	\$25 copay after deductible	\$0 copay	\$15 copay	\$0 copay
Specialist Visit	\$40 copay after deductible	\$30 copay	\$35 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$25 copay after deductible	\$0 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy	\$30 copay after deductible	\$30 copay	\$25 copay	\$0 copay
Chiropractic Care	\$40 copay after deductible	\$0 copay	\$35 copay	\$0 copay
Diagnostic Test (Lab/X–ray)	\$40 copay after deductible	Lab: \$20 copay X-ray: \$50 copay	\$35 copay	\$0 copay
Urgent Care	\$60 copay after deductible	\$60 copay	\$55 copay	\$0 copay
Emergency Services	\$150 copay after deductible	\$300 copay	\$100 copay	\$100 copay
Hospital Inpatient (per visit)	\$1,000 copay after deductible	\$725 copay	\$500 copay	\$325 copay
Pharmacy Summary	\$10/\$35/\$70	\$5 after deductible/ \$50 after deductible/ 50% after deductible	\$10/\$30/\$60	\$5 after deductible/ \$30 after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

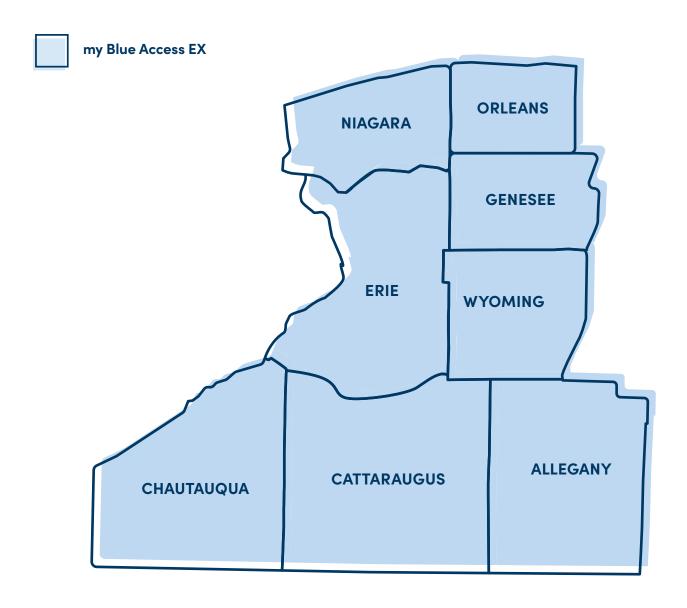
NENY — Extra Savings

Income Level	351% – 400% FPL		151% – 350% FPL	
Coverage Level	Standard Extra Savings Silver A	Destination 65 Extra Savings Silver A	Standard Extra Savings Silver B	Destination 65 Extra Savings Silver B
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$1,855 Family: \$3,710	Individual: \$0 Family: \$0	Individual: \$350 Family: \$700	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,350 Family: \$14,700	Individual: \$7,350 Family: \$14,700	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	\$30 copay after deductible	\$0 copay	\$15 copay after deductible	\$0 copay
Specialist Visit	\$65 copay after deductible	\$50 copay	\$35 copay after deductible	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$30 copay after deductible	\$0 copay	\$15 copay after deductible	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 copay after deductible	\$50 copay	\$25 copay after deductible	\$0 copay
Chiropractic Care	\$65 copay after deductible	\$0 copay	\$35 copay after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	Lab: \$50 copay after deductible X-ray: \$74 copay after deductible	Lab: \$40 copay X-ray: \$150 copay	\$35 copay after deductible	\$0 copay
Urgent Care	\$70 copay after deductible	\$100 copay	\$50 copay after deductible	\$0 copay
Emergency Services	\$275 copay after deductible	\$1,000 copay	\$75 copay after deductible	\$500 copay
Hospital Inpatient (per visit)	\$1,500 copay after deductible	\$2,000 copay	\$250 copay after deductible	\$450 copay
Pharmacy Summary	\$15/\$40/\$75	\$15 after deductible/ 50% after deductible/ 50% after deductible	\$9/\$20/\$40	\$15 after deductible/ 50% after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

NENY — Extra Savings

Income Level	138% – 150% FPL	
Coverage Level	Standard Extra Savings Silver C	Destination 65 Extra Savings Silver C
Plan Availability	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$1,075 Family: \$2,150	Individual: \$900 Family: \$1,800
Primary Care Visit	\$10 copay	\$0 copay
Specialist Visit	\$20 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$15 copay	\$0 copay
Chiropractic Care	\$20 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$20 copay	\$0 copay
Urgent Care	\$30 copay	\$0 copay
Emergency Services	\$50 copay	\$75 copay
Hospital Inpatient (per visit)	\$100 copay	\$175 copay
Pharmacy Summary	\$6/\$15/\$30	\$15 after deductible/ 50% after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes

WNY



WNY, cont.

Coverage Level	Bronze Standard	Bronze Destination 65	Silver Standard	Silver Destination 65
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$3,800 Family: \$7,600	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$50 copay after deductible	\$75 copay	\$30 copay after deductiblee	\$0 copay
Specialist Visit	\$75 copay after deductible	\$75 copay	\$65 copay after deductible	\$50 copay
Outpatient Mental Health/Substance Abuse Visits	\$50 copay after deductible	\$75 copay	\$30 copay after deductible	\$0 copay
Speech, Physical, and Occupational Therapy	\$50 copay after deductible	\$75 copay	\$30 copay after deductible	\$50 copay
Chiropractic Care	\$75 copay after deductible	\$75 copay	\$65 copay after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	Lab: \$50 copay after deductible X-ray: \$75 Copay after deductible	Lab: \$75 copay X-ray: \$155 copay	Lab: \$50 copay after deductible X-ray: \$75 copay after deductible	Lab: \$40 copay X-ray: \$150 copay
Urgent Care	\$75 copay after deductible	\$100 copay	\$70 copay after deductible	\$100 copay
Emergency Services	\$500 copay after deductible	50% after deductible	\$500 copay after deductible	\$1,000 copay
Hospital Inpatient (per visit)	\$1,500 copay after deductible	50% after deductible	\$1,500 copay after deductible	\$2,000 copay
Pharmacy Summary	\$10 after deductible/ \$35 after deductible/ \$70 after deductible	\$25*/ 50% after deductible/ 50% after deductible	\$15/\$40/\$75	\$15 after deductible/ 50% after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

^{*}Not subject to deductible

WNY, cont.

Coverage Level	Gold Standard	Gold Destination 65	Platinum Standard	Platinum Destination 65
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$600 Family: \$1,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,900 Family: \$15,800	Individual: \$7,500 Family: \$15,000	Individual: \$2,000 Family: \$4,000	Individual: \$5,000 Family: \$10,000
Primary Care Visit	\$25 copay after deductible	\$0 copay	\$15 copay	\$0 copay
Specialist Visit	\$40 copay after deductible	\$30 copay	\$35 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$25 copay after deductible	\$0 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy	\$30 copay after deductible	\$30 copay	\$25 copay	\$0 copay
Chiropractic Care	\$40 copay after deductible	\$0 copay	\$35 copay	\$0 copay
Diagnostic Test (Lab/X–ray)	\$40 copay after deductible	Lab: \$20 copay X-ray: \$50 copay	\$35 copay	\$0 copay
Urgent Care	\$60 copay after deductible	\$60 copay	\$55 copay	\$0 copay
Emergency Services	\$150 copay after deductible	\$300 copay	\$100 copay	\$100 copay
Hospital Inpatient (per visit)	\$1,000 copay after deductible	\$725 copay	\$500 copay	\$325 copay
Pharmacy Summary	\$10/\$35/\$70	\$5 after deductible/ \$50 after deductible/ 50% after deductible	\$10/\$30/\$60	\$5 after deductible/ \$30 after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

WNY — Extra Savings

Income Level	351% – 400% FPL		151% – 350% FPL	
Coverage Level	Standard Extra Savings Silver A	Destination 65 Extra Savings Silver A	Standard Extra Savings Silver B	Destination 65 Extra Savings Silver B
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: \$1,855 Family: \$3,710	Individual: \$0 Family: \$0	Individual: \$350 Family: \$700	Individual: \$0 Family: \$0
In-Network out-of- pocket maximum	Individual: \$7,350 Family: \$14,700	Individual: \$7,350 Family: \$14,700	Individual: \$3,050 Family: \$6,100	Individual: \$3,050 Family: \$6,100
Primary Care Visit	\$30 copay after deductible	\$0 copay	\$15 copay after deductible	\$0 copay
Specialist Visit	\$65 copay after deductible	\$50 copay	\$35 copay after deductible	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$30 copay after deductible	\$0 copay	\$15 copay after deductible	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 copay after deductible	\$50 copay	\$25 copay after deductible	\$0 copay
Chiropractic Care	\$65 copay after deductible	\$0 copay	\$35 copay after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	Lab: \$50 copay after deductible X-ray: \$75 copay after deductible	Lab: \$40 copay X-ray: \$150 copay	\$35 copay after deductible	\$0 copay
Urgent Care	\$70 copay after deductible	\$100 copay	\$50 copay after deductible	\$0 copay
Emergency Services	\$275 copay after deductible	\$1,000 copay	\$75 copay after deductible	\$500 copay
Hospital Inpatient (per visit)	\$1,500 copay after deductible	\$2,000 copay	\$250 copay after deductible	\$450 copay
Pharmacy Summary	\$15/\$40/\$75	\$15 after deductible/ 50% after deductible/ 50% after deductible	\$9/\$20/\$40	\$15 after deductible/ 50% after deductible/ 50% after deductible
Adult Dental and Vision Available	No	Yes	No	Yes

WNY — Extra Savings

Income Level	138% – 150% FPL			
Coverage Level	Standard Extra Savings Silver C	Destination 65 Extra Savings Silver C		
Plan Availability	my Blue Access EX	my Blue Access EX		
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0		
In-Network out-of- pocket maximum	Individual: \$1,075 Family: \$2,150	Individual: \$900 Family: \$1,800		
Primary Care Visit	\$10 copay	\$0 copay		
Specialist Visit	\$20 copay	\$0 copay		
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$0 copay		
Speech, Physical, and Occupational Therapy/Chiropractic	\$15 copay	\$0 copay		
Chiropractic Care	\$20 copay	\$0 copay		
Diagnostic Test (Lab/X-ray)	\$20 copay	\$0 copay		
Urgent Care	\$30 copay	\$0 copay		
Emergency Services	\$50 copay	\$75 copay		
Hospital Inpatient (per visit)	\$100 copay	\$175 copay		
Pharmacy Summary	\$6/\$15/\$30	\$15 after deductible/ 50% after deductible 50% after deductible		
Adult Dental and Vision Available	No	Yes		

Value-Added Benefits

Mental Well-Being

Our Mental Well-Being solution, powered by Spring Health, connects members to the most appropriate care based on their individual needs. This program provides fast access to behavioral health providers and high-quality options, from preventive care to clinical support. Members will take an assessment to create a personalized plan and get recommended resources like personalized care plans, in-network therapy, medication management, coaching, and self-guided mental exercises.

Well360 Virtual Health

Well360 Virtual Health is a virtual care solution that provides urgent care, behavioral health, dermatology, and women's health services. Members will easily and seamlessly access the entire suite of Well360 Virtual Health clinics through our fully integrated My Highmark experience. Well360 Virtual Health is available to MA members as a part of their medical benefits.

Benefits include:

- On-demand or scheduled appointments.
- Easy access to all clinics via the My Highmark app and website.
- Ability to route members to in-network services for in-person care and lab work.
- High member satisfaction ratings (75% member satisfaction and 89% ease of use).*
- Access, convenience, and time savings for members.
- Faster-time-to-treatment options with dermatology and behavioral health.

Highmark's Virtual Physical Care Program Powered by Sword

This program utilizes Sword Health, a digital musculoskeletal (MSK) care provider whose mission is to free people from chronic, acute, and post-surgical pain. Sword Health's clinical-grade digital MSK care platform pairs expert physical therapists with medical-grade wearable technology to deliver a personalized treatment plan that is more effective and easier to use. Key components of Highmark's Virtual Physical Care Program, powered by Sword include:

- Licensed physical therapists, delivering 100% of the human aspect of the program through virtual technology.
- Sensor-based technology that gives real-time feedback that's more accurate than human eyes.
- Treatment of all the major joints lower back, shoulder, neck, knee, elbow, hip, ankle, wrist.
- A program that can accommodate all phases of the spectrum: acute, chronic, pre-surgery and post-surgery rehab.
- A preventive program (self-service) that addresses low-level musculoskeletal care needs and is available to all program-eligible members, even if they are not candidates for the full program.

Value-Added Benefits may vary by product and plan year.

^{*}Source: Highmark BoB 2022.

Kidney Care Management

Individuals with chronic kidney disease and end-stage renal disease have complex treatment plans that often result in high-cost utilization and poor and frustrating member experiences. Kidney Care Management powered by Healthmap supports your clients and providers with improved care coordination and hightouch personalized services. Available at no additional cost through their Highmark health plan, your clients have access to a Care Navigation team that works hand in hand with their doctor. The Care Navigation team can help them better understand their condition, answer questions about medication, help manage and schedule doctor visits and treatment appointments, and connect them with community services for services like meals and transportation. Eligible members may receive outreach by our Healthmap team.

CHF and COPD Management

CHF and COPD Management, powered by Vida, helps individuals with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) better manage their condition and reduce or avoid hospital admissions, readmissions, and ER visits. This virtual solution allows your clients to learn how to recognize, manage and monitor their symptoms with the help of registered dietitians, health coaches, in-app trackers, learning resources, and monitoring devices. When needed, an enrolled participant has access to digital scales, blood pressure monitoring devices, and respiratory tracking devices.

^{*}Source: Highmark BoB 2022. Value-Added Benefits may vary by product and plan year.

