2025

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

Because Life.™

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PRODUCTS AND PRICING BY COUNTY

Medicare Advantage

Together Blue Medicare HMO — WPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
ELK
CAMERON
WYOMING
LACKAWANNA
SULLIVAN
PIKE
MERCER
VENANGO
CLINTON
LYCOMING
LUZERNE
CLARION
JEFFERSON
CLEARFIELD
COLUMBIA
MONTOUR
MONROE
LAWRENCE
BUTLER
CENTRE
UNION
CARBON
ARMSTRONG
NORTH UMBERLAND
SNYDER
NORTHAMPTON
BEAVER
INDIANA
MIFFLIN
SCHUYLKILL
LEHIGH
JUNIATA
CAMBRIA
BLAIR
DAUPHIN
ALLEGHENY
BERKS
BUCKS
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
SOMERSET
FAYETTE
GREENE
FULTON
FRANKLIN
ADAMS
YORK
DELAWARE

Pricing is subject to CMS approval

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

	SIGNATURE
Monthly Plan Premium	$0
Part B Premium Buyback	$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	Covered in Full (Office visit copay may apply)
Outpatient Physical and Speech Therapy	$0 Copay
Medicare Covered Acupuncture	$0 Copay
Outpatient Occupational Therapy	$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
OTC	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	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin
Medicare Covered Vision (Office Visit)	$0 Copay
Routine Vision (Office Visit)	$0 Copay (One every year)
Routine Vision (Eyewear)	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.
Medicare Covered Hearing Exam	$0 Copay
Routine Hearing Exam	$0 Copay (One every year)
Routine Hearing (Hearing Aids)	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 X-ray: $0 Copay (One every year)
Medicare Covered Comprehensive Dental	$0 Copay
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. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay
Routine Chiropractic	$15 Copay (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 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: 18%, Tier 4: 50%, Tier 5: 33% 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

Community Blue Medicare HMO — WPA

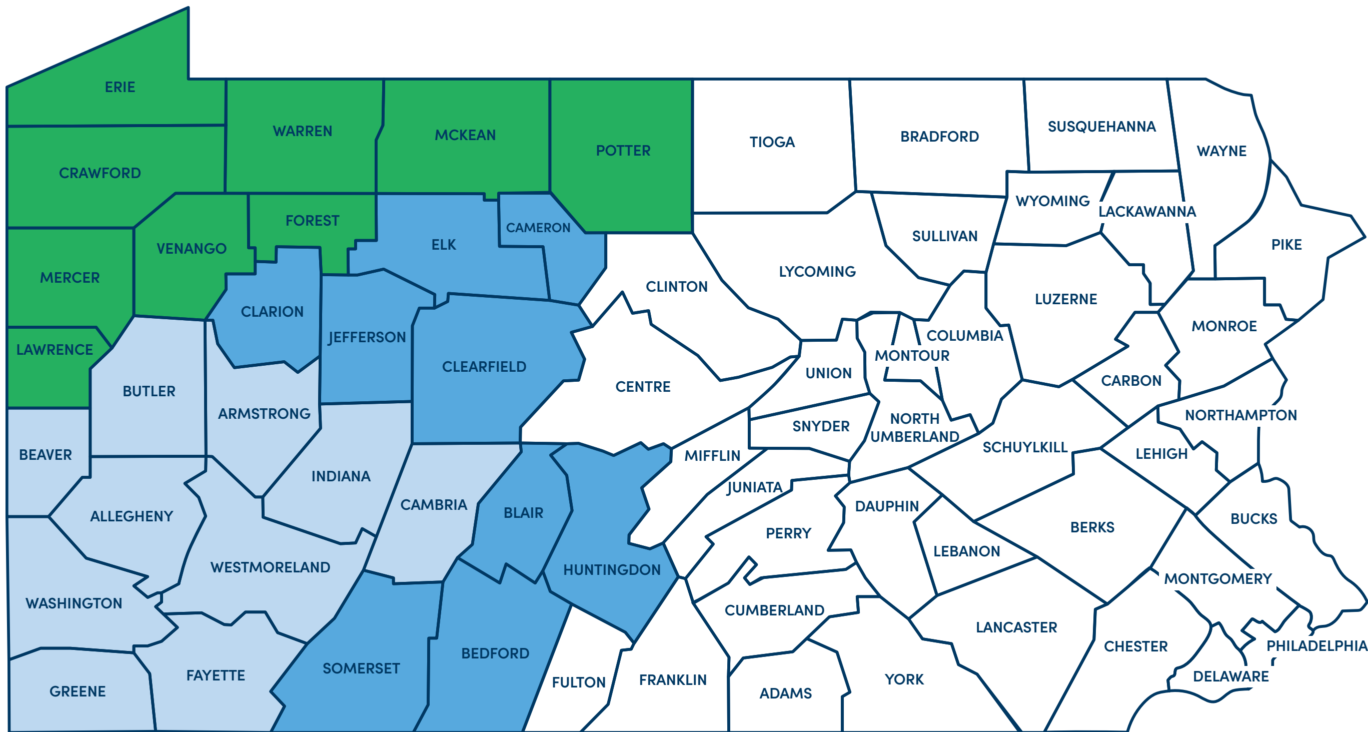
ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
ELK
CAMERON
WYOMING
LACKAWANNA
SULLIVAN
PIKE
MERCER
VENANGO
CLINTON
LYCOMING
LUZERNE
CLARION
JEFFERSON
MONROE
LAWRENCE
COLUMBIA
MONTOUR
CLEARFIELD
UNION
CARBON
BUTLER
CENTRE
ARMSTRONG
NORTH UMBERLAND
NORTHAMPTON
SNYDER
BEAVER
SCHUYLKILL
MIFFLIN
LEHIGH
INDIANA
JUNIATA
ALLEGHENY
CAMBRIA
BLAIR
DAUPHIN
BUCKS
BERKS
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
FAYETTE
SOMERSET
DELAWARE
GREENE
FULTON
FRANKLIN
YORK
ADAMS

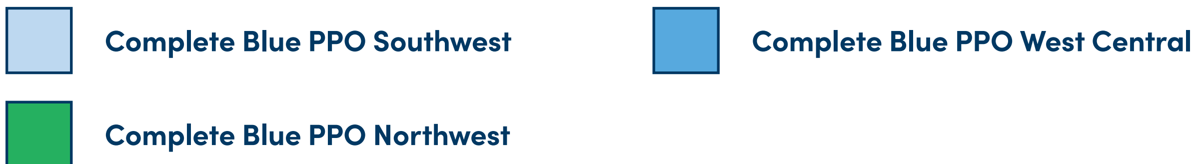
*Pricing is subject to CMS approval

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	Covered in Full (Office visit copay may apply)	
Outpatient Physical and Speech Therapy	SW/WC: $20 Copay; OW: $30 Copay	$10 Copay
Medicare Covered Acupuncture	SW/WC: $20 Copay; OW: $30 Copay	$10 Copay
Outpatient Occupational Therapy	SW/WC: $20 Copay; OW: $30 Copay	$10 Copay
Outpatient Mental Health	$40 Copay	$30 Copay
Outpatient Substance Abuse	$45 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: $275 Copay; OW: $250 Copay	$250 Copay
Transportation	$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.	
Emergency Room	$125 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	$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 (SW/GAE ONLY): $0 cost-share for DME up to a $1,000 allowance once per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only	20% Coinsurance Healing at Home: $0 cost-share for DME up to a $1,000 allowance once per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only
OTC	SW: $210 Allowance Once Per Quarter; WC: $220 Allowance Once Per Quarter; GAE: $180 Allowance Once Per Quarter	$180 Allowance Once Per Quarter
Flex Card	N/A	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.	
Health care Kits	N/A	N/A
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	20% Coinsurance up to a maximum of a $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 (One every year)	
Routine Vision (Eyewear)	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	Standard Eyeglass lenses and frames or contact lenses are covered in full. 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 (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. See EOC for benefit limits.	
Medicare Covered Chiropractic	SW/WC: $20 Copay; OW: $15 Copay	$10 Copay
Routine Chiropractic	SW/WC: $20 Copay (four visits); OW: $15 Copay (four visits)	$10 Copay (eight visits)
Medicare Covered Podiatry	SW/WC: $20 Copay; OW: $25 Copay	$0 Copay
Routine Podiatry	SW/WC: $20 Copay (four visits); OW: $25 Copay (four visits)	$0 Copay (10 visits)
Cardiac and Pulmonary Rehab, and SET, Partial Hospital, Outpatient Blood	$0 Copay	
PART D DRUGS		
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 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 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 at a retail or mail order pharmacy

Complete Blue PPO — WPA





Pricing is subject to CMS approval

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

	NEW! MERIT	NEW! CHOICE	NEW! CHOICE DELUXE
Monthly Plan Premium	$0	$0	$6
Part B Premium Buyback	WC/NW: $84; SW: $83	$19	$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) Facility: $325 Copay IN+; $375 Copay OON+	ASC: $200 Copay IN; $325 Copay OON Facility: $300 Copay IN; $375 Copay OON	ASC: $200 Copay IN; $200 Copay OON Facility: $300 Copay IN; $300 Copay OON
Ambulance	Emergent/Non-Emergent: $375 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $375 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $400 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.		
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 6 – 90) IN+; $475/day (days 1 – 3), $0/day (days 4 – 90) OON+	$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $475/day (days 1 – 3), $0/day (days 4 – 90) OON	$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $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+	$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	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+		20% Coinsurance IN; 30% Coinsurance OON
OTC	$40 Allowance Once Per Quarter	Covered in Flex Card benefit	Covered in Flex Card benefit
Flex Card	N/A	Dental, Vision, Hearing, OTC — $445	WC/NW: Dental, Vision, Hearing, OTC — $430; Part B — $200 ($50 Transaction Limit); SW: Dental, Vision, Hearing, OTC — $425; 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		
Health care Kits	N/A		
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+	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)	$40 Copay IN; $50 Copay OON+	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 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	$40 Copay IN; $50 Copay OON+	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One every year)	$20 Copay IN; $20 Copay OON (One every year)	$10 Copay IN; $10 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, cleaning, and fluoride treatment; X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$40 Copay IN; $50 Copay OON+	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500	Combined maximum allowance of $4,000	Combined maximum allowance of $6,000
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).		
Medicare Covered Chiropractic	$15 Copay IN+; $35 OON+	$15 Copay IN; $35 OON	$15 Copay IN; $15 OON
Routine Chiropractic	$15 Copay IN; $35 Copay OON (four visits)	$15 Copay IN; $35 Copay OON (four visits)	$15 Copay IN; $15 Copay OON (four visits)
Medicare Covered Podiatry	$40 Copay IN; $50 Copay OON+	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Podiatry	$40 Copay IN; $50 Copay OON (four visits)	$30 Copay IN; $30 Copay OON (four visits)	$25 Copay IN; $25 Copay OON (four visits)
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			
Formulary	Lean (Performance)	Lean (Performance)	Lean (Performance)
Deductible	Tier 1 –Tier 2: $0, Tier 3 – Tier 5: $550	$0	$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: $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 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: $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 a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 21%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 21%, Tier 4: 25%, Tier 5: 25%	Preferred 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%	Preferred Mail: Tier 1: $0, Tier 2: $0, 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%
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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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	$150 Copay IN; $150 Copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON			
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 Facility: $245 Copay IN; $375 Copay OON	ASC: $175 Copay IN; $300 Copay OON Facility: $225 Copay IN; $350 Copay OON	ASC: $175 Copay IN; $175 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $125 Copay IN; $125 Copay OON Facility: $200 Copay IN; $200 Copay OON
Ambulance	Emergent/Non-Emergent: $260 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $390 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $260 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $270 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.			
Emergency Room	$125 Copay			
Urgent Care	$50 Copay	$50 Copay	$30 Copay	$15 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$145/day (days 1 – 5) IN, $0/day (days 6 – 90) IN; $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; $475/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	$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $475/day (days 1 – 3), $0/day (days 4 – 90) OON	$300/admit IN; $300/admit 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	20% Coinsurance IN; 30% Coinsurance OON			
OTC	SW: $165 Allowance Once Per Quarter WC: $170 Allowance Once Per Quarter	$150 Allowance Once Per Quarter	$105 Allowance Once Per Quarter	SW: $185 Allowance Once Per Quarter WC: $195 Allowance Once Per Quarter NW: $190 Allowance Once Per Quarter
Flex Card	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. 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	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)	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$10 Copay IN; $10 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 $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	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$10 Copay IN; $10 Copay OON	$0 Copay IN; $0 Copay OON
Routine Hearing Exam	$25 Copay IN; $25 Copay OON (One every year)	$25 Copay IN; $25 Copay OON (One every year)	$10 Copay IN; $10 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, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)			
Medicare Covered Comprehensive Dental	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$10 Copay IN; $10 Copay OON	$0 Copay IN; $0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500	Combined maximum allowance of $2,500	Combined maximum allowance of $3,000	Combined maximum allowance of $3,500
Comprehensive Dental — Supplemental	20% Coinsurance: 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.		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 EOC for benefit limits.	$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable/fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN; $35 OON	$15 Copay IN; $30 OON	$15 Copay IN; $15 OON	$20 Copay IN; $20 Copay OON
Routine Chiropractic	$15 Copay IN; $35 Copay OON (four visits)	$15 Copay IN; $30 Copay OON (four visits)	$15 Copay IN; $15 Copay OON (four visits)	$20 Copay IN; $20 Copay OON (eight visits)
Medicare Covered Podiatry	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$10 Copay IN; $10 Copay OON	$0 Copay IN; $0 Copay OON
Routine Podiatry	$20 Copay IN; $20 Copay OON (four visits)	$20 Copay IN; $20 Copay OON (four visits)	$10 Copay IN; $10 Copay OON (four visits)	$0 Copay IN; $0 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	Lean (Performance)	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: $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: $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: $7, Tier 2: $20, 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: $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 a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred 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%	Preferred 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%	Preferred Mail: Tier 1: $0, Tier 2: $0, 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%	Preferred Mail: Tier 1: $0, Tier 2: $0, 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%
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			

Security Blue HMO-POS — WPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
CAMERON
WYOMING
LACKAWANNA
VENANGO
ELK
SULLIVAN
PIKE
MERCER
CLINTON
LYCOMING
LUZERNE
CLARION
MONROE
LAWRENCE
JEFFERSON
COLUMBIA
MONTOUR
CLEARFIELD
UNION
CARBON
BUTLER
CENTRE
ARMSTRONG
NORTH UMBERLAND
NORTHAMPTON
SNYDER
BEAVER
MIFFLIN
SCHUYLKILL
LEHIGH
INDIANA
JUNIATA
CAMBRIA
BLAIR
DAUPHIN
ALLEGHENY
BERKS
BUCKS
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
PHILADELPHIA
CHESTER
BEDFORD
SOMERSET
FAYETTE
FULTON
FRANKLIN
YORK
DELAWARE
GREENE
ADAMS

**Pricing is subject to CMS approval*

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

	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	$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; $25 Copay POS	$10 Copay IN; $15 Copay POS	$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	$60 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	Covered in Full (Office visit copay may apply) IN/POS			
Outpatient Physical, Speech and Occupational Therapy, Mental Health, and Substance Abuse	$30 Copay IN; $45 Copay POS	$40 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS	Occupational Therapy: $20 Copay IN; $30 Copay 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 Facility: $200 Copay IN; $250 Copay POS	ASC: $175 Copay IN; $225 Copay POS Facility: $200 Copay IN; $250 Copay POS	ASC: $125 Copay IN; $175 Copay POS Facility: $175 Copay IN; $225 Copay POS	ASC: $75 Copay IN; $125 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 trip is part of continued acute care after discharge from ER.			
Emergency Room	$125 Copay			
Urgent Care	$50 Copay	$5 Copay		
Inpatient Hospital 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
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); $214/day (days 21 – 100) IN			
Home Health	$0 Copay IN			
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			
Durable Medical Equipment	20% Coinsurance IN	20% Coinsurance IN; Healing at Home (SW Only): $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only		
Non-Skilled Care	N/A	(SW Only) Healing at Home: $0 cost-share for 50 hours of non-skilled in home care related services per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only		
OTC	N/A			
Flex Card	N/A			
Meal Benefit	28 Meals/14 Days IN upon discharge from an inpatient hospital stay, inpatient hospital psychiatric stay, or SNF stay to the home to qualify			
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			
Health care Kits	N/A			
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 POS			
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN; $35 Copay POS			
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)	$0 Copay IN (One every year)			
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. A $225 benefit maximum applies to non-standard frames or a $225 benefit maximum for specialty contact lenses. $200 benefit maximum for post 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 (One every year)			
Routine Hearing (Hearing Aids)	Two Hearing Aids every year IN; TruHearing Advanced — $599 copay; TruHearing Premium — $899 copay			Two Hearing Aids every year IN; TruHearing Advanced — $399 copay; TruHearing Premium — $699 copay
Routine Dental	Office Visit: $15 Copay IN (One every six months) 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 General 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, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance POS			
PART D DRUGS				
Formulary	N/A	Lean (Performance)	Base (Venture)	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.	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, Tier 3: $47, Tier 4: $100, Tier 5: 33%	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%
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	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, 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%
OOP Threshold	N/A	$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	N/A	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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Freedom Blue PPO — WPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
WYOMING
LACKAWANNA
FOREST
CAMERON
SULLIVAN
PIKE
VENANGO
ELK
MERCER
CLINTON
LYCOMING
LUZERNE
CLARION
MONROE
COLUMBIA
JEFFERSON
LAWRENCE
MONTOUR
CLEARFIELD
UNION
CARBON
BUTLER
CENTRE
ARMSTRONG
NORTHAMPTON
NORTH UMBERLAND
SNYDER
BEAVER
SCHUYLKILL
LEHIGH
MIFFLIN
INDIANA
JUNIATA
CAMBRIA
DAUPHIN
BLAIR
ALLEGHENY
BUCKS
BERKS
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
BEDFORD
PHILADELPHIA
CHESTER
SOMERSET
FAYETTE
DELAWARE
FULTON
FRANKLIN
YORK
GREENE
ADAMS

Pricing is subject to CMS approval

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

	VALUERx	SELECT	CLASSIC
Monthly Plan Premium	SW: $45; WC: $42	SW: $139; WC: $96	SW: $252; WC: $224
Part B Premium Buyback	$0	$0	$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, Mental Health, and Substance Abuse	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
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 Facility: $200 Copay IN; $200 Copay OON	ASC: $125 Copay IN; $125 Copay OON Facility: $175 Copay IN; $175 Copay OON	ASC: $75 Copay IN; $75 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	$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.		
Emergency Room	$125 Copay		
Urgent Care	$5 Copay		
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$220/day (days 1 – 5), $0/day (days 6 – 90) IN; $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; $220/day (days 1 – 5), $0/day (days 6 – 90) OON	$350/admit IN; $350/admit OON	$210/admit IN; $210/admit 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 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		
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		
OTC	N/A		
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON	SW: 20% Coinsurance IN; 30% Coinsurance OON; Healing at Home: $0 cost-share for DME up to a $1,000 allowance once per calendar year within 90 Days of Discharge from Inpatient Acute Hospital IN/OON WC: 20% Coinsurance IN; 30% CoinsuranceOON	
OTC	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 Inpatient Acute Hospital IN/OON; WC: N/A	
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	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)	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 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 $225 benefit maximum applies to non-standard frames and a $225 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Hearing Exam	$0 Copay IN; $40 Copay OON (One every year)	$0 Copay IN; $30 Copay OON (One every year)	$0 Copay IN; $25 Copay OON (One every year)
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — $599 copay; TruHearing Premium — $899 copay IN; $500 allowance IN/OON for any other hearing aid		
Routine Dental	Office Visit: $15 Copay IN; 30% Coinsurance OON (One every six months) X-ray: $15 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Comprehensive Dental — Supplemental	$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON		
Medicare Covered Chiropractic	$15 Copay IN; $15 Copay OON	$15 Copay IN; $15 Copay OON	$15 Copay IN; $15 Copay OON
Routine Chiropractic	$15 Copay IN; $15 Copay OON (six visits)	$15 Copay IN; $15 Copay OON (eight visits)	$15 Copay IN; $15 Copay OON (10 visits)
Medicare Covered Podiatry	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Podiatry	$40 Copay IN; $40 Copay OON (eight visits)	$30 Copay IN; $30 Copay OON (10 visits)	$25 Copay IN; $25 Copay OON (12 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	Lean (Performance)	Base (Venture)	Base (Venture)
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.	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, 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 to 31-days supply)	Prefered Mail Order: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail Order: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, 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		

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

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**

NEW PLAN

Complete Blue PPO Choice Deluxe

All WPA counties

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**

Complete Blue PPO Distinct

All WPA counties

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

Complete Blue PPO Premier

All WPA 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 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**

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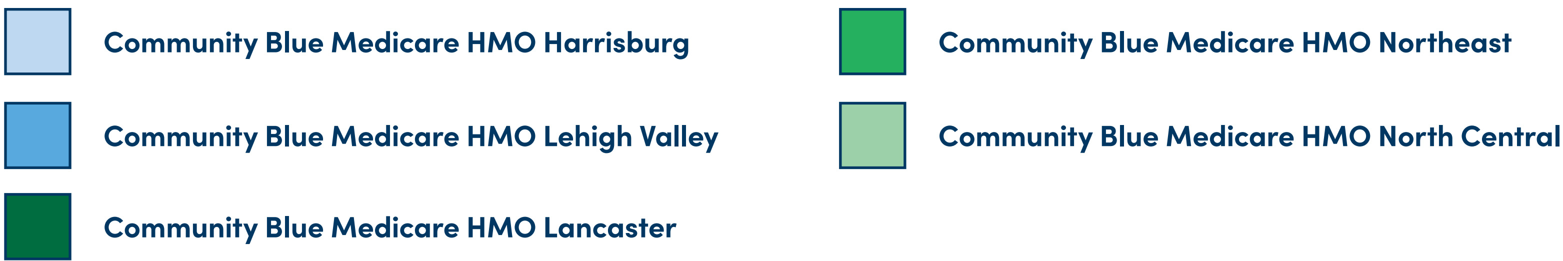
Community Blue Medicare HMO — CPA/NEPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
CAMERON
WYOMING
LACKAWANNA
PIKE
MERCER
VENANGO
ELK
CLINTON
LYCOMING
SULLIVAN
LUZERNE
CLARION
JEFFERSON
CLEARFIELD
CENTRE
UNION
MONTOUR
COLUMBIA
MONROE
LAWRENCE
BUTLER
ARMSTRONG
CARBON
NORTHAMPTON
BEAVER
INDIANA
SNYDER
NORTH UMBERLAND
SCHUYLKILL
LEHIGH
MIFFLIN
JUNIATA
CAMBRIA
BLAIR
DAUPHIN
ALLEGHENY
PERRY
BERKS
BUCKS
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
FAYETTE
SOMERSET
DELAWARE
GREENE
FULTON
FRANKLIN
ADAMS
YORK

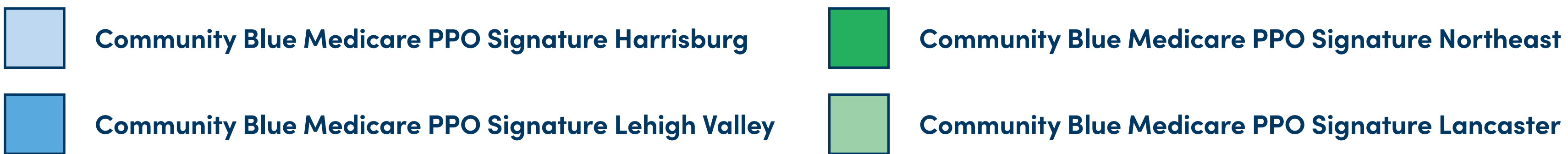


*Pricing is subject to CMS approval

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 Copay	
Radiation Therapy	$60 Copay	
Advanced Imaging	$200 Copay	
Preventive/Screening	Covered in Full (Office visit copay may apply)	
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 Copay	
Outpatient Substance Abuse	$45 Copay	
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 continued acute care after discharge from ER.	
Emergency Room	$125 Copay	
Urgent Care	$0 Copay	
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); $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	
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 endocrinologist and receive a glucometer with an unlimited supply of test strips	
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.	
Health care Kits	N/A	
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 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	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin	
Medicare Covered Vision (Office Visit)	$0 Copay	
Routine Vision (Office Visit)	$0 Copay (One every year)	$0 Copay (One every year)
Routine Vision (Eyewear)	Standard Eyeglass lenses and frames or contact lenses are covered in full. 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	$0 Copay	
Routine Hearing Exam	$0 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	
Routine Dental	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	$0 Copay	
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. See EOC for benefit limits.	
Medicare Covered Chiropractic	$10 Copay	
Routine Chiropractic	$10 Copay (four visits)	
Medicare Covered Podiatry	$0 Copay	
Routine Podiatry	$0 Copay (four visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay	
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: $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%	
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	

Community Blue Medicare PPO Signature — CPA/NEPA



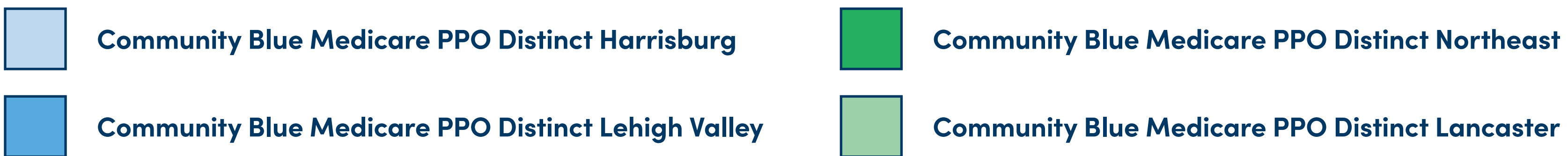
**Pricing is subject to CMS approval*

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

	SIGNATURE	
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	$0 Copay IN; $0 Copay OON	
Specialist Office Visit	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)	Lehigh Valley/Harrisburg: $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 visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	Lehigh Valley/Harrisburg: $35 Copay IN; $60 Copay OON; 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; Northeast: $25 Copay IN; $50 Copay OON	$30 Copay IN; $60 Copay OON
Outpatient Occupational Therapy	$30 Copay IN; $60 Copay OON	
Outpatient Mental Health	$40 Copay IN; $60 Copay OON	
Outpatient Substance Abuse	$45 Copay IN; $60 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 is part of continued acute care after discharge from ER.	
Emergency Room	$110 Copay	
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 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	Lehigh/Harrisburg: $145 Allowance Once Per Quarter. Northeast: $155 Allowance Once Per Quarter	$145 Allowance Once Per Quarter
Flex Card	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. 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	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)	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 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.	
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 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, cleaning, and fluoride treatment; X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)	
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 allowance of $2,500	
Comprehensive Dental — Supplemental	20% Coinsurance: 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	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); Northeast: $15 Copay IN; $35 Copay OON (four visits)	$15 Copay IN; $15 OON (four visits)
Medicare Covered Podiatry	Lehigh Valley/Harrisburg: $25 Copay IN; $25 Copay OON; Northeast: $20 Copay IN; $20 Copay OON	$25 IN; $25 OON
Routine Podiatry	Lehigh Valley/Harrisburg: $25 Copay IN; $25 Copay OON (four visits); Northeast: $20 Copay IN; $20 Copay OON (four visits)	$25 Copay IN; $25 OON (four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON	
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: $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%	
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 (31-day supply): 33% Standard Mail Order: Tier 1: $21, Tier 2: $45, Tier 3: 25%, Tier 4: 50%, Tier 5 (31-day supply): 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	

Community Blue Medicare PPO Distinct — CPA/NEPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
CAMERON
WYOMING
LACKAWANNA
SULLIVAN
PIKE
MERCER
VENANGO
ELK
LYCOMING
CLINTON
LUZERNE
CLARION
JEFFERSON
COLUMBIA
MONROE
LAWRENCE
CLEARFIELD
MONTOUR
UNION
BUTLER
CENTRE
CARBON
ARMSTRONG
SNYDER
NORTH UMBERLAND
NORTHAMPTON
BEAVER
SCHUYLKILL
MIFFLIN
LEHIGH
INDIANA
JUNIATA
CAMBRIA
DAUPHIN
BUCKS
ALLEGHENY
BLAIR
PERRY
BERKS
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
BEDFORD
CHESTER
PHILADELPHIA
FAYETTE
SOMERSET
DELAWARE
FULTON
FRANKLIN
YORK
GREENE
ADAMS

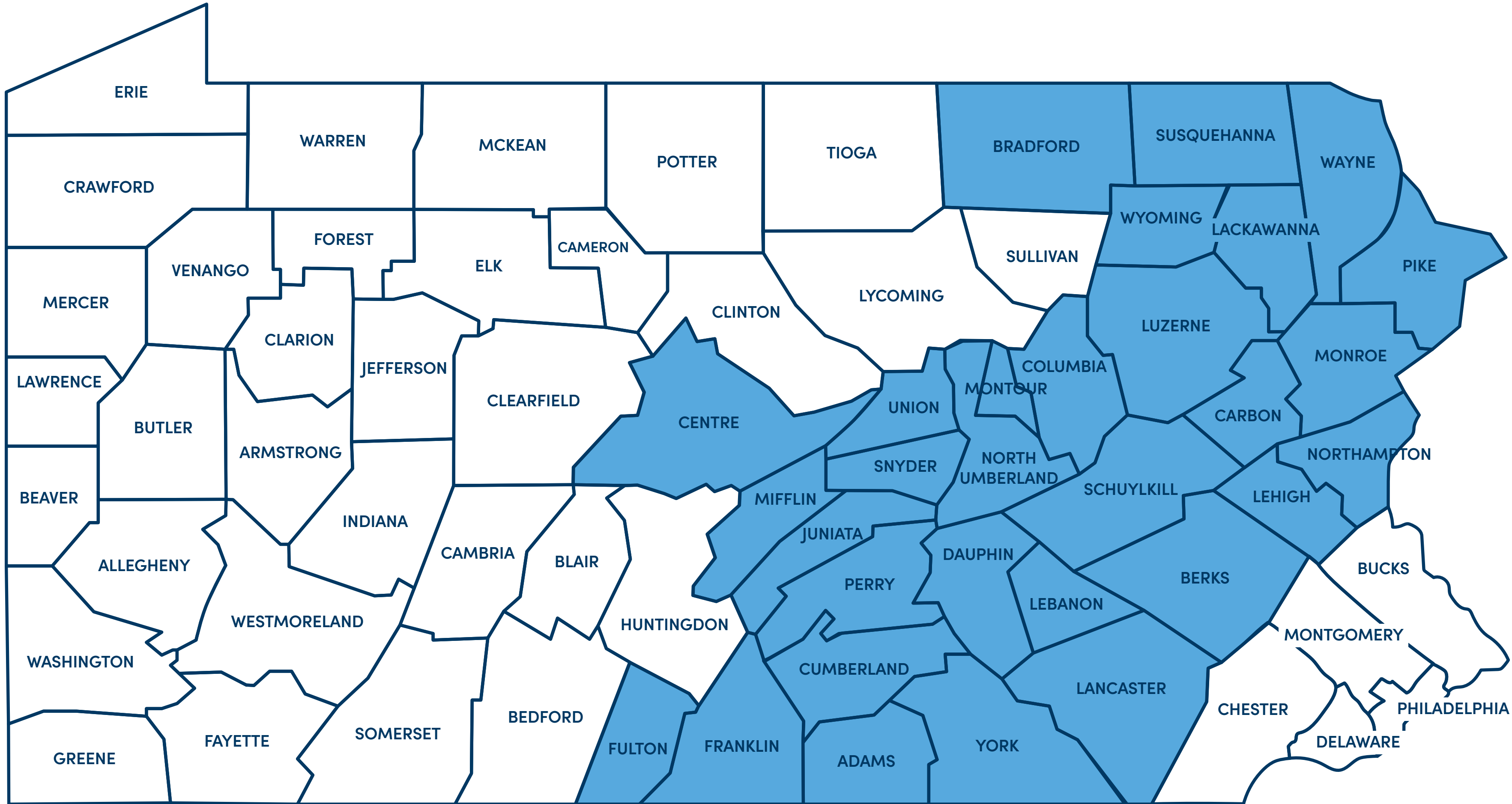


*Pricing is subject to CMS approval

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; $0 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)	$0 Copay IN; $0 Copay OON	
Lab and Diagnostic Tests (Outpatient Facility)	$0 Copay IN; $0 Copay OON	
X-rays	$20 Copay IN; $20 Copay OON	$15 Copay IN; $15 Copay OON
Radiation Therapy	$60 Copay IN; $60 Copay OON	
Advanced Imaging	$175 Copay IN; $175 Copay OON	
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	$15 Copay IN; $15 Copay OON	
Medicare Covered Acupuncture	$15 Copay IN; $15 Copay OON	
Outpatient Occupational Therapy	$30 Copay IN; $30 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: $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 is part of continued acute care after discharge from ER.	
Emergency Room	$125 Copay	
Urgent Care	$30 Copay	$10 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$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) 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	20% Coinsurance IN; 30% Coinsurance OON	
OTC	Lehigh Valley/Harrisburg: $100 Allowance Once Per Quarter Northeast: $95 Allowance Once Per Quarter	$95 Allowance Once Per Quarter
Flex Card	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. 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 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)	$15 Copay IN; $15 Copay OON	$5 Copay IN; $5 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	$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)	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, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance 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	Combined maximum allowance of $3,000	
Comprehensive Dental — Supplemental	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 EOC for benefit limits.	
Medicare Covered Chiropractic	$15 Copay IN; $15 OON	
Routine Chiropractic	$15 Copay IN; $15 OON (four visits)	
Medicare Covered Podiatry	$15 IN; $15 OON	$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	$0 Copay IN; 30% Coinsurance OON	
PART D DRUGS		
	Lean (Performance)	
Network	PA MPVN 25k CVS w/BPM Wrap	
Deductible	$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: $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%	
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	

Community Blue Medicare PPO Premier — CPA/NEPA



Community Blue Medicare PPO Premier

*Pricing is subject to CMS approval

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	Network: $4,900; Combined: $8,950
PCP Office Visit	$0 Copay IN; $0 Copay OON
Specialist Office Visit	$0 Copay IN; $0 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	$0 Copay IN; $0 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	$0 Copay IN; $0 Copay OON
X-rays	$20 Copay IN; $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	$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	$125 Copay
Urgent Care	$15 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$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) 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	20% Coinsurance IN; 30% Coinsurance OON
OTC	$185 Allowance Once Per Quarter
Flex Card	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. 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	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	$0 Copay IN; $0 Copay OON
Routine Hearing Exam	$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, 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. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$20 Copay IN; $20 Copay OON
Routine Chiropractic	$20 Copay IN; $20 Copay OON (eight visits)
Medicare Covered Podiatry	$0 Copay IN; $0 Copay OON
Routine Podiatry	$0 Copay IN; $0 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON
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 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%
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

Community Blue Medicare Plus PPO — NEPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
WYOMING
LACKAWANNA
FOREST
CAMERON
ELK
SULLIVAN
PIKE
MERCER
VENANGO
CLINTON
LYCOMING
LUZERNE
CLARION
JEFFERSON
COLUMBIA
MONROE
LAWRENCE
CLEARFIELD
MONTOUR
CENTRE
UNION
CARBON
BUTLER
ARMSTRONG
NORTH UMBERLAND
SNYDER
NORTHAMPTON
BEAVER
INDIANA
SCHUYLKILL
MIFFLIN
LEHIGH
JUNIATA
CAMBRIA
BLAIR
DAUPHIN
BERKS
BUCKS
ALLEGHENY
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
SOMERSET
FAYETTE
FULTON
FRANKLIN
YORK
DELAWARE
GREENE
ADAMS

*Pricing is subject to CMS approval

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 Facility: $350 Copay IN; $400 Copay OON	ASC: $175 Copay IN; $175 Copay OON Facility: $245 Copay IN; $245 Copay OON	ASC: $175 Copay IN; $175 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	$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.		
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; $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	$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 – 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	$165 Allowance Once Per Quarter	$100 Allowance Once Per Quarter	$180 Allowance Once Per Quarter
Flex Card	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. 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	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)	$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 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	$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)	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, cleaning, and fluoride treatment; X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$25 Copay IN; $25 Copay OON	$15 Copay IN; $15 Copay OON	$0 Copay IN; $0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500	Combined maximum allowance of $3,000	Combined maximum allowance of $3,000
Comprehensive Dental — Supplemental	20% Coinsurance: 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; $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, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON		
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	$2,000. 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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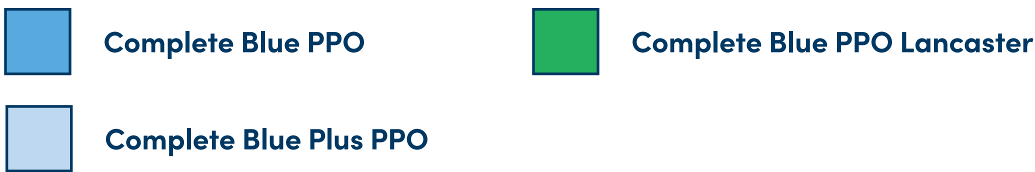
New! Complete Blue PPO and Complete Blue Plus PPO — CPA/NEPA



**Pricing is subject to CMS approval*

Confidential and Proprietary — For Agent Use Only

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	$25 Copay IN; $60 Copay OON	$20 Copay IN; $20 Copay OON
Outpatient Mental Health	$40 Copay IN; $60 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 Facility: $350 Copay IN; $400 Copay OON	ASC: $250 Copay IN; $250 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 is part of continued acute care after discharge from ER.	
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; $300/day (days 1 – 7), $0/day (days 8 – 90) OON	$415/admit IN; $415/admit 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 – 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	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	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)	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 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	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One every year)	$15 Copay IN; $15 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, cleaning, and fluoride treatment; X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)	
Medicare Covered Comprehensive Dental	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $3,500	Combined maximum allowance of $5,000
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: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative. 50% All others).
Medicare Covered Chiropractic	$15 Copay IN; $35 OON	$15 Copay IN; $15 OON
Routine Chiropractic	$15 Copay IN; $35 Copay OON (four visits)	$15 Copay IN; $15 Copay OON (four visits)
Medicare Covered Podiatry	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Routine Podiatry	$30 Copay IN; $30 Copay OON (four visits)	$25 Copay IN; $25 Copay OON (four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON	
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: $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: $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: 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%	Preferred 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%
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	

Freedom Blue PPO

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
ELK
CAMERON
WYOMING
LACKAWANNA
SULLIVAN
PIKE
MERCER
VENANGO
CLINTON
LYCOMING
LUZERNE
CLARION
JEFFERSON
CLEARFIELD
MONROE
LAWRENCE
COLUMBIA
MONTOUR
UNION
CENTRE
CARBON
BUTLER
ARMSTRONG
NORTH UMBERLAND
SNYDER
NORTHAMPTON
BEAVER
MIFFLIN
SCHUYLKILL
LEHIGH
INDIANA
JUNIATA
ALLEGHENY
CAMBRIA
BLAIR
DAUPHIN
BUCKS
PERRY
BERKS
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
SOMERSET
FAYETTE
FULTON
FRANKLIN
YORK
DELAWARE
GREENE
ADAMS

Freedom Blue PPO

**Pricing is subject to CMS approval*

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; $60 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 Therapy, Mental Health, and Substance Abuse	$35 Copay IN; $35 Copay OON	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Medicare Covered Acupuncture	$35 Copay IN; $35 Copay OON	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Outpatient Surgical	ASC: $100 Copay IN; $100 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $200 Copay IN; $200 Copay OON Facility: $225 Copay IN; $225 Copay OON	ASC: $150 Copay IN; $150 Copay OON Facility: $200 Copay IN; $200 Copay OON	ASC: $100 Copay IN; $100 Copay OON Facility: $175 Copay IN; $175 Copay OON
Ambulance	Emergent/Non-Emergent: $125 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $260 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $215 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $140 IN; Non-Emergent: 30% Coinsurance OON
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 discharge from ER.			
Emergency Room	$125 Copay			
Urgent Care	$50 Copay	$5 Copay	$5 Copay	$5 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$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
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	$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			
OTC	N/A			
Flex Card	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. 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			
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	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)	$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)	$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 $225 benefit maximum applies to non-standard frames and a $225 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.			
Medicare Covered Hearing Exam	$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 Hearing Exam	$0 Copay IN; $35 Copay OON (One every year)	$0 Copay IN; $40 Copay OON (One every year)	$0 Copay IN; $35 Copay OON (One every year)	$0 Copay IN; $30 Copay OON (One every year)
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year; TruHearing Advanced — $599 copay; TruHearing Premium — $899 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
Routine Dental	Office Visit: $15 Copay IN; 30% Coinsurance OON (One every six months) X-ray: $15 Copay IN; 30% Coinsurance OON (One every year)			
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	$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON			
Medicare Covered Chiropractic	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON	$20 Copay IN; $20 Copay OON
Routine Chiropractic	$20 Copay IN; $20 Copay OON (eight visits)	$20 Copay IN; $20 Copay OON (six visits)	$20 Copay IN; $20 Copay OON (eight visits)	$20 Copay IN; $20 Copay OON (10 visits)
Medicare Covered Podiatry	$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 Podiatry	$35 Copay IN; $35 Copay OON (10 visits)	$40 Copay IN; $40 Copay OON (eight visits)	$35 Copay IN; $35 Copay OON (10 visits)	$30 Copay IN; $30 Copay OON (12 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	N/A	Lean (Performance)	Base (Venture)	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.	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, 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 to 31-days supply)	N/A	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%		
OOP Threshold	N/A	$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	N/A	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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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.

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New! Complete Blue PPO — SEPA

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
WYOMING
LACKAWANNA
FOREST
CAMERON
ELK
SULLIVAN
PIKE
MERCER
VENANGO
LYCOMING
CLINTON
LUZERNE
CLARION
JEFFERSON
MONROE
COLUMBIA
LAWRENCE
MONTOUR
CLEARFIELD
UNION
CARBON
BUTLER
CENTRE
ARMSTRONG
NORTH UMBERLAND
NORTHAMPTON
SNYDER
SCHUYLKILL
BEAVER
MIFFLIN
LEHIGH
INDIANA
JUNIATA
ALLEGHENY
CAMBRIA
DAUPHIN
BUCKS
BLAIR
BERKS
PERRY
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
SOMERSET
DELAWARE
FAYETTE
FRANKLIN
YORK
FULTON
GREENE
ADAMS

Pricing is subject to CMS approval

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)	$0 Copay IN; $0 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	Covered in Full (Office visit 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 Facility: $300 Copay IN; $300 Copay OON	ASC: $150 Copay IN; $150 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	$0 Copay IN; 30% Coinsurance OON. Covered only if trip 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; $475/day (days 1 – 3), $0/day (days 4 – 90) OON	$300/admit IN; $300/admit 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	20% Coinsurance IN; 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 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	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)	$25 Copay IN; $25 Copay OON	$20 Copay IN; $20 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	$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, cleaning, 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	$0 Copay IN; 30% Coinsurance OON	
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 a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, 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%	Preferred Mail: Tier 1: $0, Tier 2: $0, 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%
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	

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

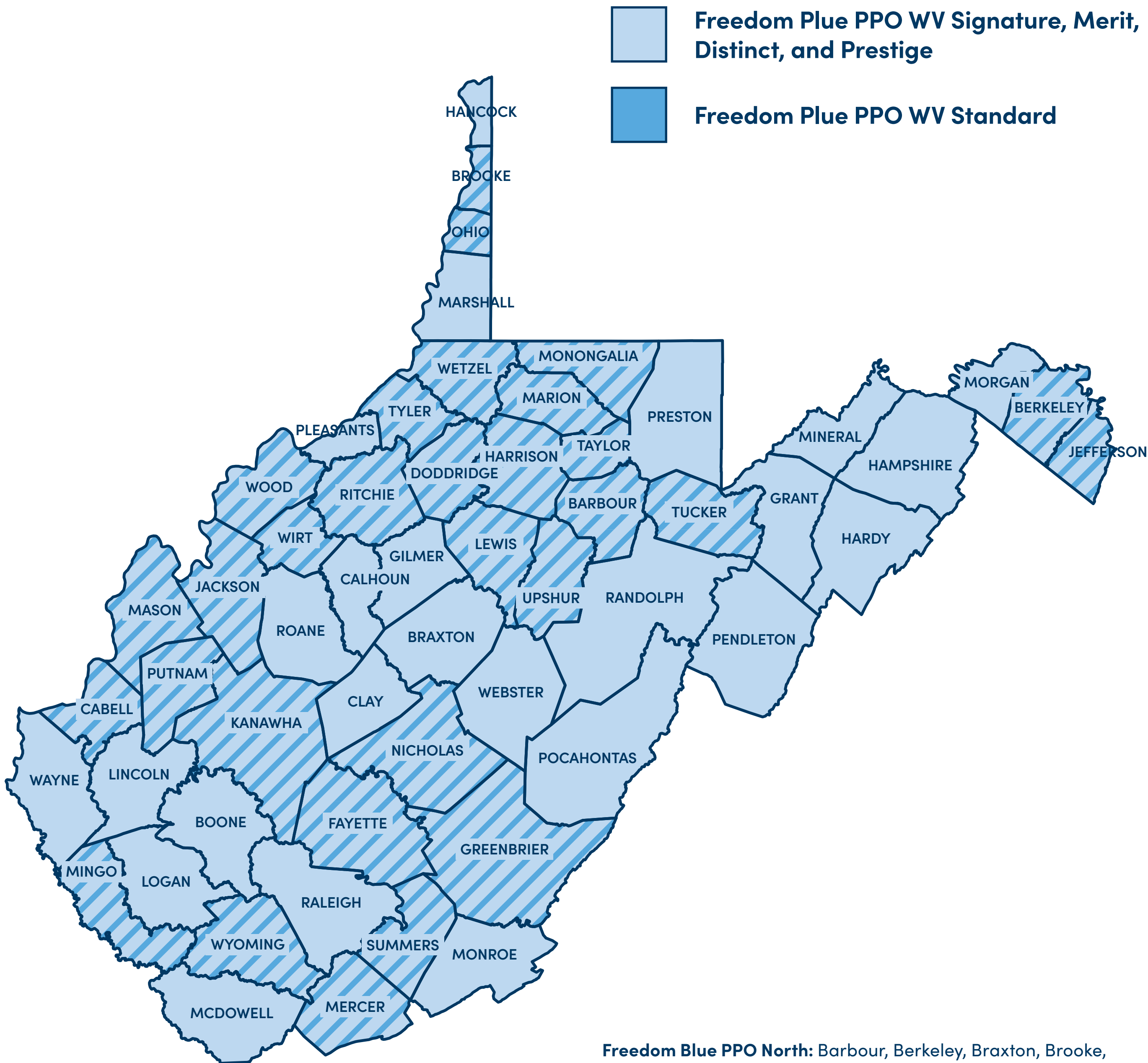
Bucks, Chester, Montgomery, and Philadelphia counties

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



Freedom Blue PPO North: Barbour, Berkeley, Braxton, Brooke, Calhoun, Doddridge, Gilmer, Grant, Hampshire, Hancock, Hardy Harrison, Jefferson, Lewis, Marion, Marshall, Mineral, Monongalia, Morgan, Ohio, Pendleton, Pleasants, Preston, Randolph, Ritchie, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt, and Wood counties.

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.

**Pricing is subject to CMS approval*

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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	Network: $8,300; Combined: $13,000	Network: $7,000; Combined: $10,000
Medical Deductible (+ 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	Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	North: $45 Copay IN+; $55 Copay OON+ South: $25 Copay IN+; $55 Copay OON+	$30 Copay IN; $50 Copay OON
Medicare Covered Acupuncture	North: $45 Copay IN+; $55 Copay OON+ South: $25 Copay IN+; $55 Copay OON+	$30 Copay IN; $50 Copay OON
Outpatient Occupational Therapy	North: $35 Copay IN+; $50 Copay OON+ South: $25 Copay IN+; $50 Copay OON+	$30 Copay IN; $50 Copay OON
Outpatient Mental Health	$40 Copay IN+; $50 Copay OON+	$40 Copay IN; $50 Copay OON
Outpatient Substance Abuse	$40 Copay IN+; $50 Copay OON+	$40 Copay IN; $50 Copay OON
Outpatient Surgical	ASC: $300 Copay IN+; $375 Copay OON+ 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	$45 Copay	$35 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	North: $455/day (days 1 – 5), $0/day (days 6 – 90) IN+; $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 (days6 – 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	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+	20% Coinsurance IN; 30% Coinsurance OON
OTC	N/A	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	$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	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+	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)	North: $45 Copay IN; $65 Copay OON+ South: $35 Copay IN; $65 Copay OON+	$25 Copay IN; $25 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.	
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 months) Includes exam, cleaning and flouride treatment X-ray: $0 Copay IN; 30% Coinsurance 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	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 20% Coinsurance IN. Adjunct general services: Palliative 0%, all others 20% Coinsurance 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	$15 Copay IN; $40 Copay OON (four visits)	$15 Copay IN; $40 OON (eight visits)
Medicare Covered Podiatry	North: $45 Copay IN; $65 Copay OON+ South: $35 Copay IN; $65 Copay OON+	$25 Copay IN; $25 Copay OON
Routine Podiatry	North: $45 Copay IN; $65 Copay OON (8 visits) South: $35 Copay IN; $65 Copay OON (8 visits)	$25 Copay IN; $25 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	Cardiac Rehab: $15 Copay IN+; 30% Coinsurance OON+ 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	$75 Copay IN; $75 Copay OON
Covered in Full (Office visit copay may apply) IN/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; $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	$150/day (days 1 – 7), $0/day (days 8 – 90) 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	$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
$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 30% Coinsurance OON	$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 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		
20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON
North: $75 Allowance Once Per Quarter South: $95 Allowance Once Per Quarter	$75 Allowance Once Per Quarter	N/A
N/A	N/A	N/A
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		
$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 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 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		
$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)		
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 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 six months) Includes exam, cleaning and flouride treatment X-ray: $0 Copay IN; 30% Coinsurance 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 Copay IN; $25 Copay OON	$0 Copay IN; $0 Copay OON	$35 IN; $35 OON
$20 Copay IN; $25 OON (10 visits)	$0 Copay IN; $0 Copay OON (10 visits)	$35 Copay IN; $35 OON (10 visits)
$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 30% Coinsurance OON

Continued on next page

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

	MERIT	SIGNATURE
PART D DRUGS		
Formulary	Lean (Performance)	
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: $0, Tier 2: $5, Tier 3: 25%, Tier 4: 46%, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $20, 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, 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: $7, Tier 2: $15, Tier 3: 25%, Tier 4: 50%, Tier 5: 33%	Preferred Retail: Tier 1: $0, Tier 2: $11, Tier 3: $45, Tier 4: $100, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: $100, 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%	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: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail Order: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, 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	Tier 3 Insulin: $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	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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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

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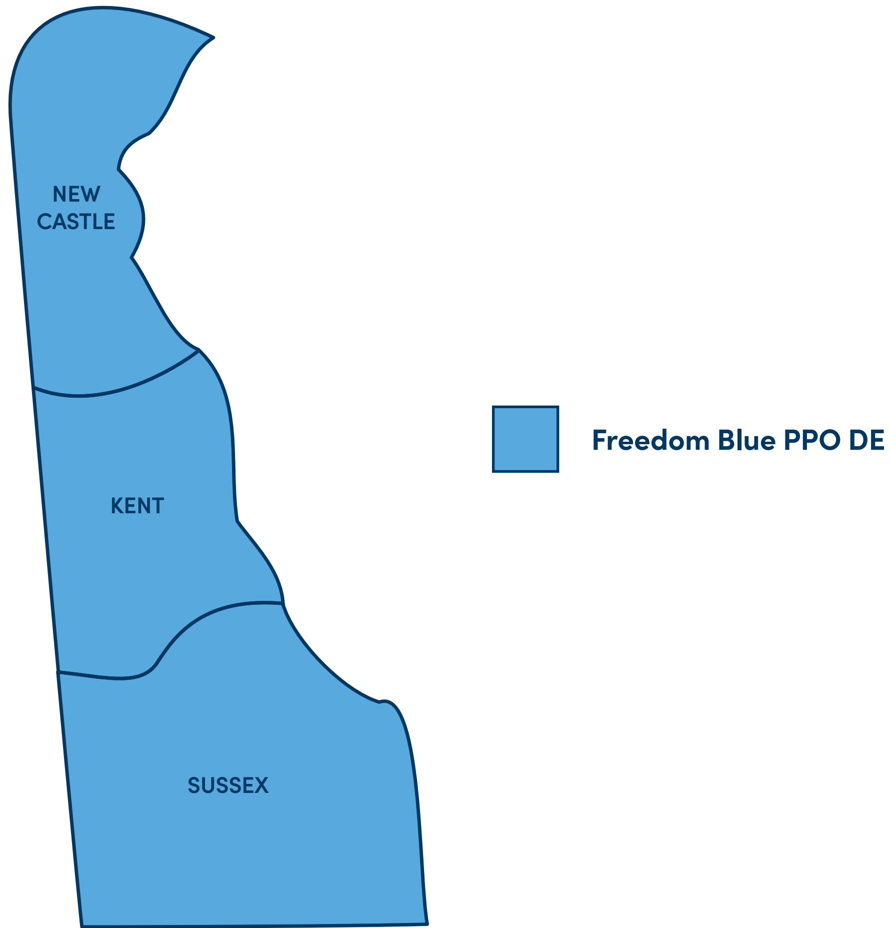
Freedom Blue PPO — DE



**Pricing is subject to CMS approval*

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

	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	$60 Copay IN; $75 Copay OON		
Advanced Imaging	$225 Copay IN; $350 Copay OON	$250 Copay IN; $300 Copay OON	$150 Copay IN; $300 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	$25 Copay IN; $50 Copay OON	$0 Copay IN; $40 Copay OON
Medicare Covered Acupuncture	$25 Copay IN; $50 Copay OON	$25 Copay IN; $50 Copay OON	$0 Copay IN; $40 Copay OON
Outpatient Occupational Therapy	$30 Copay IN; $50 Copay OON	$25 Copay IN; $50 Copay OON	$30 Copay IN; $40 Copay OON
Outpatient Mental Health	$40 Copay IN; $50 Copay OON	$30 Copay IN; $45 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 Facility: $300 Copay IN; $350 Copay OON	ASC: $250 Copay IN; $300 Copay OON Facility: $350 Copay IN; $400 Copay OON	ASC: $155 Copay IN; $300 Copay OON Facility: $200 Copay IN; $300 Copay OON
Ambulance	Emergent/Non-Emergent: $225 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $250 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $250 IN; Non-Emergent: 30% Coinsurance OON
Transportation	N/A		
Emergency Room	$125 Copay	$125 Copay	$110 Copay
Urgent Care	$40 Copay	$50 Copay	$0 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$220/day (days 1 – 5), $0/day (days 6 – 90) IN; $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; $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	$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		
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	$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	N/A	N/A	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
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	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)	$30 Copay IN; $30 Copay OON	$30 Copay IN; $30 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.		
Medicare Covered Hearing Exam	$30 Copay IN; $30 Copay OON	$30 Copay IN; $30 Copay OON	$0 Copay IN; $0 Copay OON
Routine Hearing Exam	$30 Copay IN; $30 Copay OON (One every year)	$30 Copay IN; $30 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	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 months) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$30 Copay IN; $30 Copay OON	$30 Copay IN; $30 Copay OON	$0 Copay IN; $0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2000	Combined maximum allowance of $2500	Combined maximum allowance of $3500
Comprehensive Dental — Supplemental	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.	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.	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 $3500 Allowance IN/OON for all services. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN; $30 OON	$10 Copay IN; $15 Copay OON	$0 Copay IN; $0 OON
Routine Chiropractic	$15 Copay IN; $30 OON (eight visits)	$10 Copay IN; $15 OON (eight visits)	$0 Copay IN; $0 OON (eight visits)
Medicare Covered Podiatry	$30 Copay IN; $30 Copay OON	$30 Copay IN; $30 Copay OON	$0 Copay IN; $0 Copay OON
Routine Podiatry	$30 Copay IN; $30 OON (10 visits)	$30 Copay IN; $30 OON (10 visits)	$0 Copay IN; $0 OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON		
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: $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%	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: 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: Tier 1: $0, Tier 2: $0, 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%	Preferred 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%	Preferred 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%
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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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

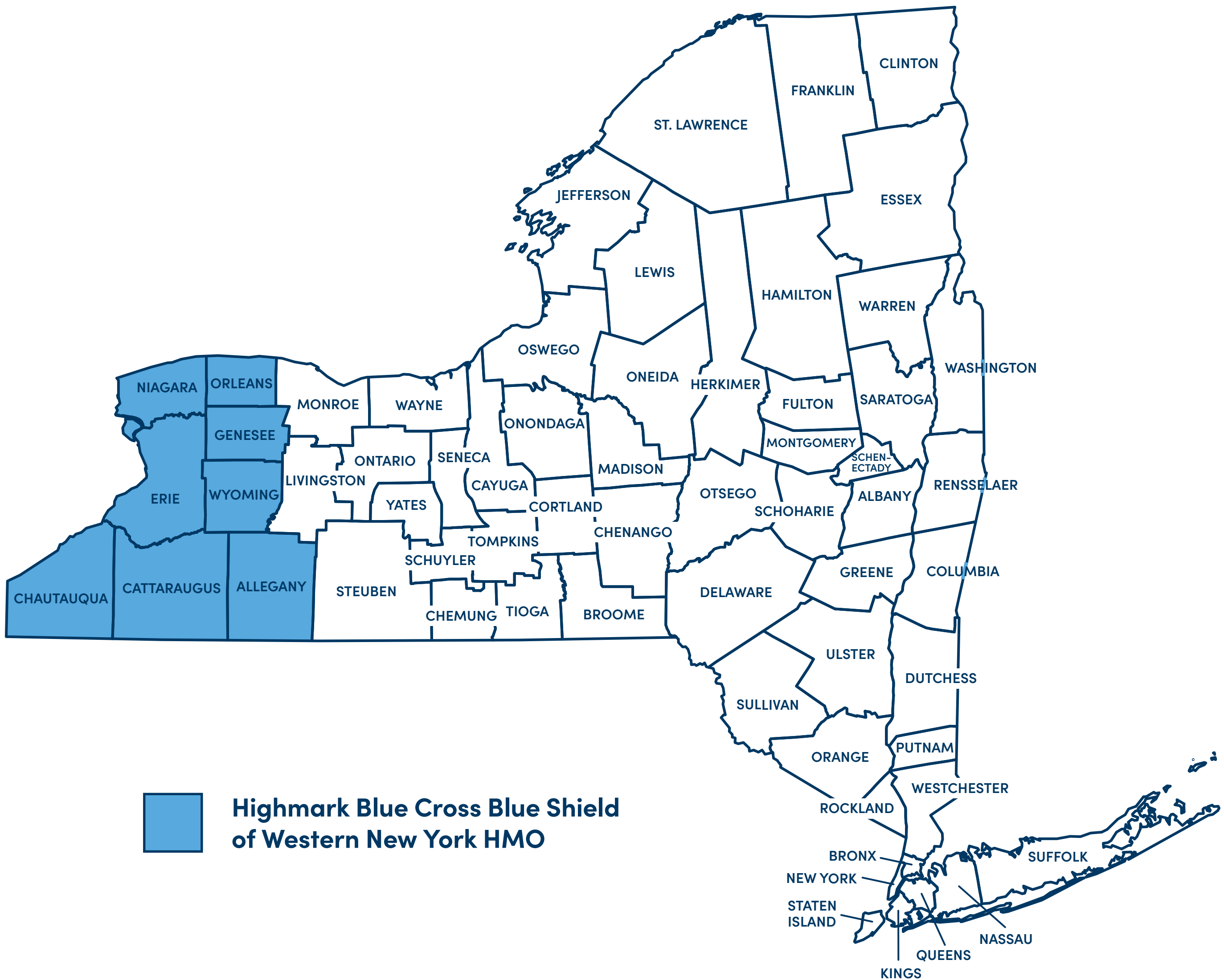
All DE Counties

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	$50 Copay IN	$30 Copay IN
Outpatient Occupational Therapy	$35 Copay IN	$30 Copay IN
Outpatient Mental Health	$40 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	N/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 days 21 – 100. No yearly benefit period maximum.	
Home Health	$0 Copay IN	
Diabetic Supplies and Services	$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.).	
Durable Medical Equipment	$0 compression stockings, diabetic shoes/inserts; 20% all other items	
OTC	N/A	$140 quarterly allowance
Flex Card	N/A	N/A
Meal Benefit	$0 for 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.	
Onduo	$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips	
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 IN	
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $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 year)	Office: $0 Copay IN; (One every six months) Includes exam, cleaning and flouride treatment; X-ray: $0 Copay IN (One every year)
Medicare Covered Comprehensive Dental	$50 Copay IN	$30 Copay IN
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1000	Combined maximum allowance of $2000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings $20 Copay IN. See EOC for benefit limits.	Restorative Services: medicament application 0%, all others: 50% Coinsurance.Endodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 50% . Periodontal cleanings/ maintenance $0 Copay, all other periodontal services: 50% Coinsurance. Adjunct general services: 0% palliative, all others: 50% Coinsurance. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN	
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, Outpatient Blood	Cardiac Rehab: $10 Copay IN Partial Hospital: $55 Copay IN Outpatient Blood: $0 Copay IN	Cardiac Rehab: $10 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. 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: $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 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%
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: 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%	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%
OOP Threshold	$2,000. Once that is met, the plan pays the full cost for covered Part D drugs.	$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 (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

SENIOR BLUE 601 HMO	SENIOR BLUE SELECT HMO	SENIOR BLUE 651 HMO
$0	$40	$101
$1	$0	$0
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	$175 Copay IN	$150 Copay IN
$0 Copay IN	$0 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
$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 maximum.		
$0 Copay IN		
$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.).		
$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 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		
$0 behavioral health care program with digital tools, coaching, in-person and virtual clinical support to help members address behavioral health needs.		
$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.		
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 for all other Part B drugs IN		
20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin		
$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	$200 Allowance for routine eyewear	$200 Allowance for routine eyewear
$45 Copay IN	$30 Copay IN	$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; TruHearing Premium — $899 copay	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 (One every six months) Includes exam and cleaning X-ray: $0 Copay IN (One every year)	Office: $0 Copay IN (One every six months) Includes exam and cleaning X-ray: $0 Copay IN (One every year)	Office: $0 Copay IN (One every six months) Includes exam and cleaning 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: $0 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.
$15 Copay IN		
$15 Copay IN (six per plan year)	$15 Copay IN (12 per plan year)	$15 Copay IN (12 per plan year)
$45 Copay IN	$30 Copay IN	$25 Copay IN
$45 Copay IN (three visits)	$30 Copay IN (three visits)	$25 Copay IN (three visits)
Cardiac Rehab: $15 Copay IN Partial Hospital: $55 Copay IN Outpatient Blood: $0 Copay IN	Cardiac Rehab: $15 Copay IN Partial Hospital: $55 Copay IN Outpatient Blood: $0 Copay IN	Cardiac Rehab: $15 Copay IN Partial Hospital: $55 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, Tier 3: 25%, Tier 4: 40%, Tier 5: 33%	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, 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.	$2,000. Once that has been met, the plan pays the full cost for covered Part D drugs.
N/A	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

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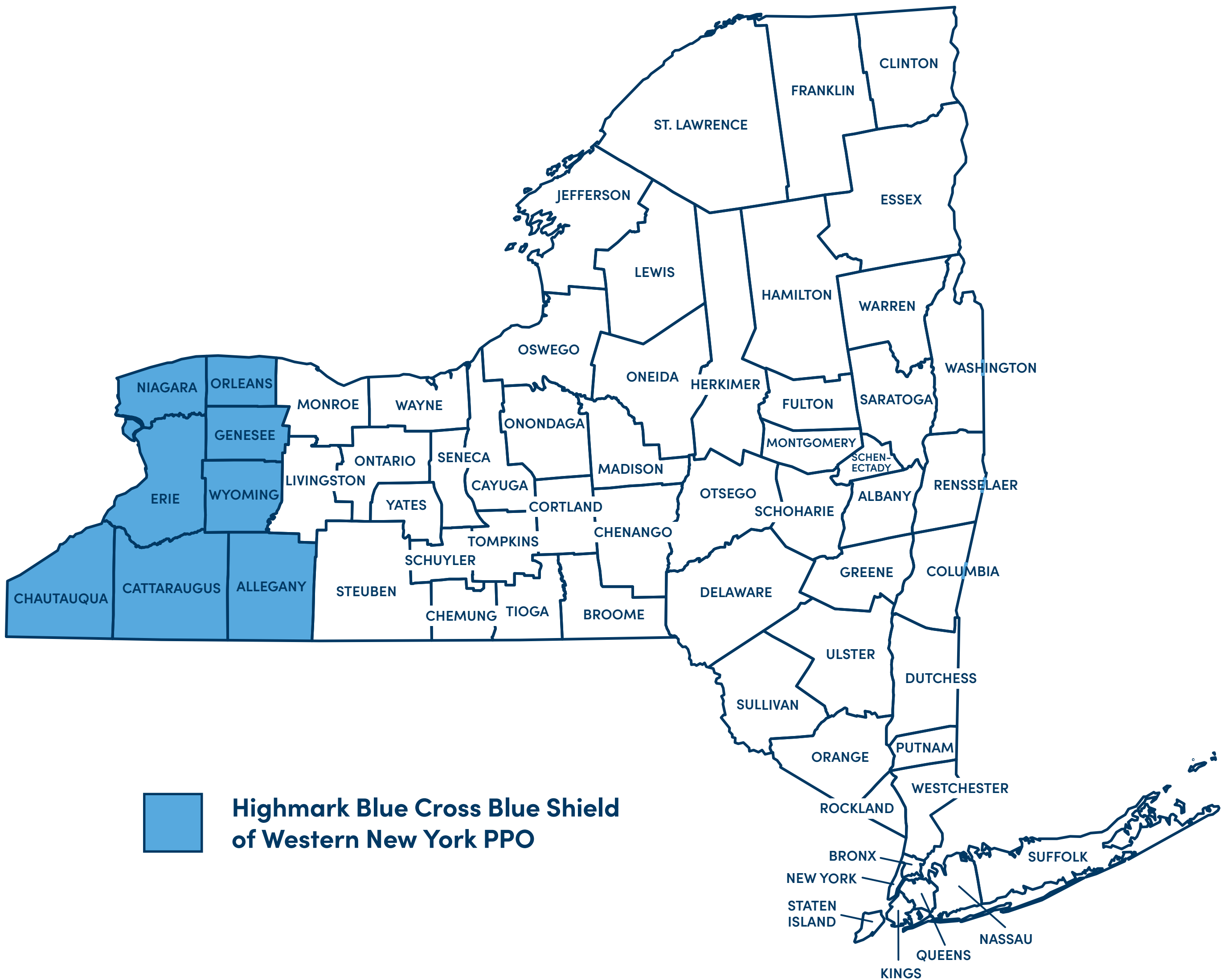
Highmark Blue Cross Blue Shield of Western New York PPO



Pricing is subject to CMS approval

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

	FREEDOM NATION PPO	NEW! FREEDOM NATION PRESTIGE PPO
Monthly Plan Premium	$30	$52
Part B Premium Buyback	$0	$4
Out-of-Pocket Maximum	Network: $6,750; Combined: $10,100	Network: $6,750; Combined: $10,100
PCP Office Visit	$0 Copay IN; 50% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Specialist Office Visit	$30 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	$5 Lab Copay IN; $50 Diagnostic Tests IN; Lab $5 Copay OON; Dignostic Test 50% Coinsurance OON	$0 Lab Copay IN; $50 Diagnostic Tests IN; Lab $0 Copay OON; Dignostic Test 50% Coinsurance OON
Lab and Diagnostic Tests (Outpatient Facility)	$5 Lab Copay IN; $50 Diagnostic Tests IN; Lab $5 Copay OON; Dignostic Test 50% Coinsurance OON	$0 Lab Copay IN; $50 Diagnostic Tests IN; Lab $0 Copay OON; Dignostic Test 50% Coinsurance OON
X-rays	$50 Copay IN; 50% Coinsurance OON	$50 Copay IN; 50% Coinsurance OON
Radiation Therapy	20% Coinsurance IN; 50% Coinsurance OON	20% Coinsurance IN; 50% Coinsurance OON
Advanced Imaging	$200 Copay IN; 50% Coinsurance OON	$200 Copay IN; 50% Coinsurance OON
Preventive/Screening	$0 Copay IN; 50% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Outpatient Physical and Speech Therapy	$25 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Medicare Covered Acupuncture	$30 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Outpatient Occupational Therapy	$25 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Outpatient Mental Health	$40 Copay IN; 50% Coinsurance OON	$40 Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse	$40 Copay IN; 50% Coinsurance OON	$40 Copay IN; 50% Coinsurance OON
Outpatient Surgical	ASC: $275 Copay IN; 50% Coinsurance OON Facility: $375 Copay IN; 50% Coinsurance OON	ASC: $250 Copay IN; 50% Coinsurance OON Facility: $350 Copay IN; 50% Coinsurance OON
Ambulance	$325 Copay	$325 Copay
Transportation	N/A	
Emergency Room	$125 Copay	
Urgent Care	$55 Copay	
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	$375 per day for days 1 – 6, $2,250 OOP Max per year IN; 50% Coinsurance OON	$305 per day for days 1-6, $1,830 OOP Max per year IN; 50% Coinsurance OON
Inpatient Psychiatry Stay	$370 per day for days 1 – 5, $1,850 OOP Max per year IN; 50% Coinsurance OON	$305 per day for days 1-6, $1,830 OOP Max per year IN; 50% Coinsurance OON
Skilled Nursing Facility	$0 per day for days 1 – 20; $214 per day for days 21 – 100, No yearly benefit period maximum IN; 50% Coinsurance OON	$0 per day for days 1-20; $214 per day for days 21-100, No yearly benefit period maximum IN; 50% Coinsurance OON
Home Health	$0 Copay IN; 50% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Diabetic Supplies and Services	$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	
Durable Medical Equipment	$0 compression stockings, diabetic shoes/inserts; 20% all other items IN; 50% Coinsurance OON	
OTC	$160 quarterly allowance	$75 quarterly allowance
Flex Card	N/A	
Meal Benefit	$0 for 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.	
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	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 IN; 50% 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)	$30 (except $0 for diabetic retinal eye exam); 50% Coinsurance OON	$10 (except $0 for diabetic retinal eye exam); 50% Coinsurance OON
Routine Vision (Office Visit)	$25 Copay IN; 20% Coinsurance OON (One every year)	$0 Copay IN; 20% Coinsurance OON (One every year)
Routine Vision (Eyewear)	$100 Allowance for routine eyewear	$200 Allowance for routine eyewear
Medicare Covered Hearing Exam	$30 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Routine Hearing Exam	$45 Copay (One every year)	$25 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 — $699 copay; TruHearing Premium — $999 copay
Routine Dental	Office: $0 Copay IN; $0 Copay OON (One every six months) Includes exam, cleaning and flouride treatment X-ray: $0 Copay IN (One every year); $0 Copay OON	Office: $0 Copay IN; $0 Copay OON (One every six months) Includes exam, cleaning and flouride treatment X-ray: $0 Copay IN; $0 Copay OON (One every year)
Medicare Covered Comprehensive Dental	$30 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2000	Combined maximum allowance of $3000
Comprehensive Dental — Supplemental	Restorative Services: medicament application 0%, all others 50% coinsurance IN. All services: 50% Coinsurance OON. 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 0% Coinsurance, all others: 50% Coinsurance IN; All services: 50% Coinsurance 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/OONAdjunct general services: palliative 0% Coinsurance, all others: 50% Coinsurance IN/OONSee EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN; 50% Coinsurance OON	$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic	$15 Copay IN (six per plan year); 50% Coinsurance OON	$15 Copay IN; 50% Coinsurance OON (six per plan year)
Medicare Covered Podiatry	$30 Copay IN; 50% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
Routine Podiatry	$30 Copay IN; 50% Coinsurance OON (three visits)	$10 Copay IN; 50% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	Cardiac Rehab: $10 Copay IN; 50% Coinsurance OON Partial Hospital: $55 copay IN; 50% Coinsurance OON Outpatient Blood: $0 Copay IN; 50% Coinsurance OON	Cardiac Rehab: $10 Copay IN; 50% Coinsurance OON Partial Hospital: $55 copay IN; 50% Coinsurance OON Outpatient Blood: $0 Copay IN; 50% Coinsurance OON
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. 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: 49%, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $17, Tier 3: 25%, Tier 4: 49%, 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: $17, 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: Tier 1: $0, Tier 2: $0, Tier 3: 25%, Tier 4: 49%, Tier 5: 33% Standard Mail: Tier 1: $12.50, Tier 2: $42.50, Tier 3: 25%, Tier 4: 49%, 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%
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 (excludes deductible): $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy

FOREVER BLUE VALUE PPO	FOREVER BLUE 751 PPO
$131	$197
$0	$0
Network: $6,700; Catastrophic: $10,000	Network: $6,700 Catastrophic: $10,000
$0 – $10 Copay IN; 35% Coinsurance OON	$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	$40 Copay IN; 25% Coinsurance OON
20% Coinsurance IN; 35% 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; 35% 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	$40 Copay IN; 50% Coinsurance OON
ASC: $250 Copay IN; 35% Coinsurance OON Facility: $350 Copay IN; 35% Coinsurance OON	ASC: $200 Copay IN; 25% Coinsurance OON Facility: $300 Copay IN; 25% Coinsurance OON
$250 Copay	$225 Copay
N/A	
$125 Copay	
$55 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; 35% Coinsurance OON	$0 per day for days 1 – 20; $214 per day for days 21 – 100, No yearly benefit period maximum IN; 30% Coinsurance OON
$0 Copay IN; 35% Coinsurance OON	$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	
$0 compression stockings, diabetic shoes/inserts; 20% all other items IN; 50% Coinsurance OON	
$60 quarterly allowance	$60 quarterly allowance
N/A	
$0 for 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; 50% Coinsurance OON	
20% Coinsurance up to a maximum of a $35 copay 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
$25 Copay IN; 20% Coinsurance 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
$45 Copay (One 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	$25 Copay IN; 25% Coinsurance OON
$30 Copay IN; 35% Coinsurance OON (three visits)	$25 Copay IN; 25% Coinsurance OON (three visits)
Cardiac Rehab: $5 Copay IN; 35% Coinsurance OON Partial Hospital: $55 copay IN; 35% Coinsurance OON Outpatient Blood: $0 Copay IN; 35% Coinsurance OON	Cardiac Rehab: $15 Copay IN; 25% Coinsurance OON Partial Hospital: $55 copay IN; 25% Coinsurance OON Outpatient Blood: $0 Copay IN; 25% Coinsurance OON
N/A	N/A
PART D 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%
$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	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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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

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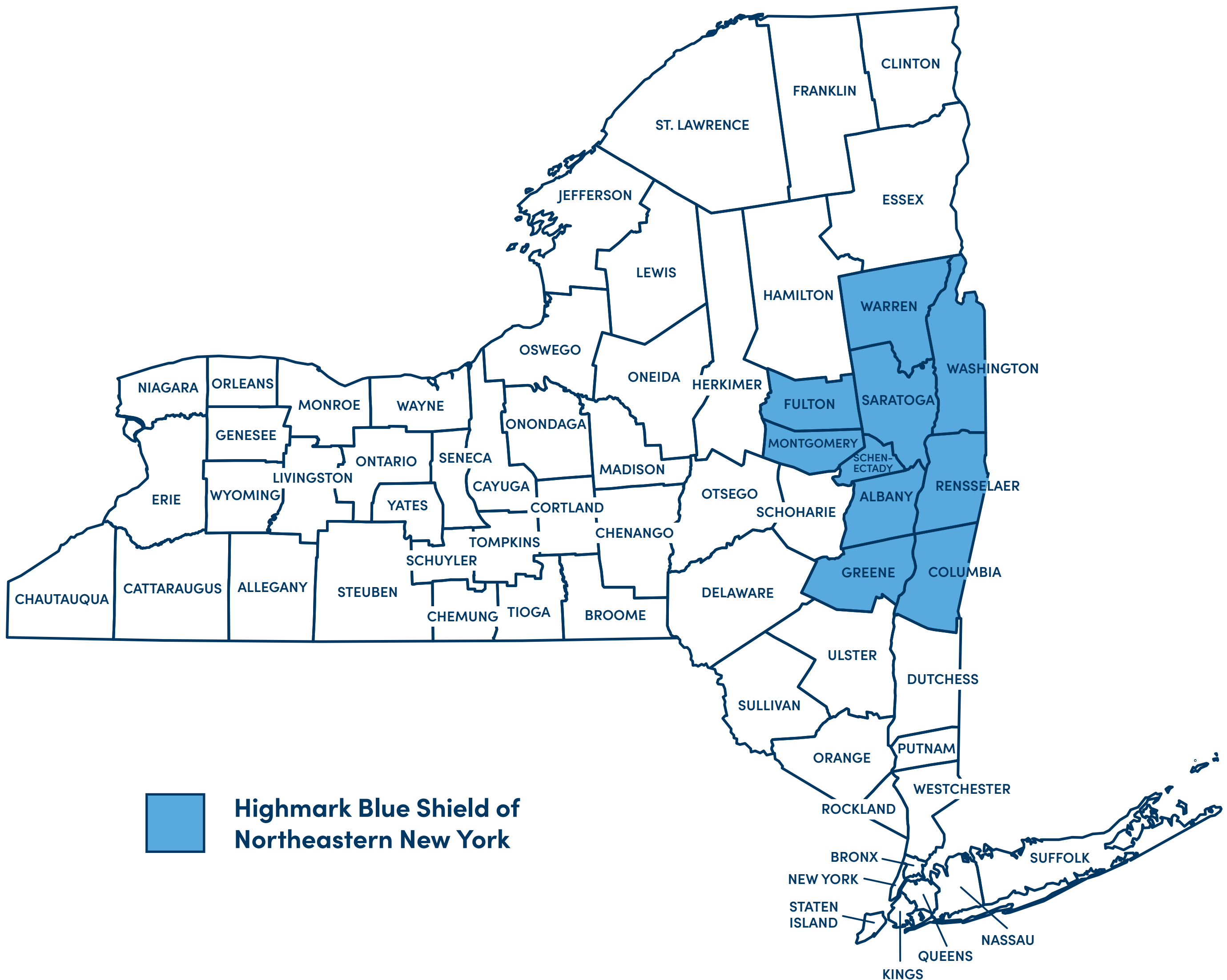
Highmark Blue Shield of Northeastern New York



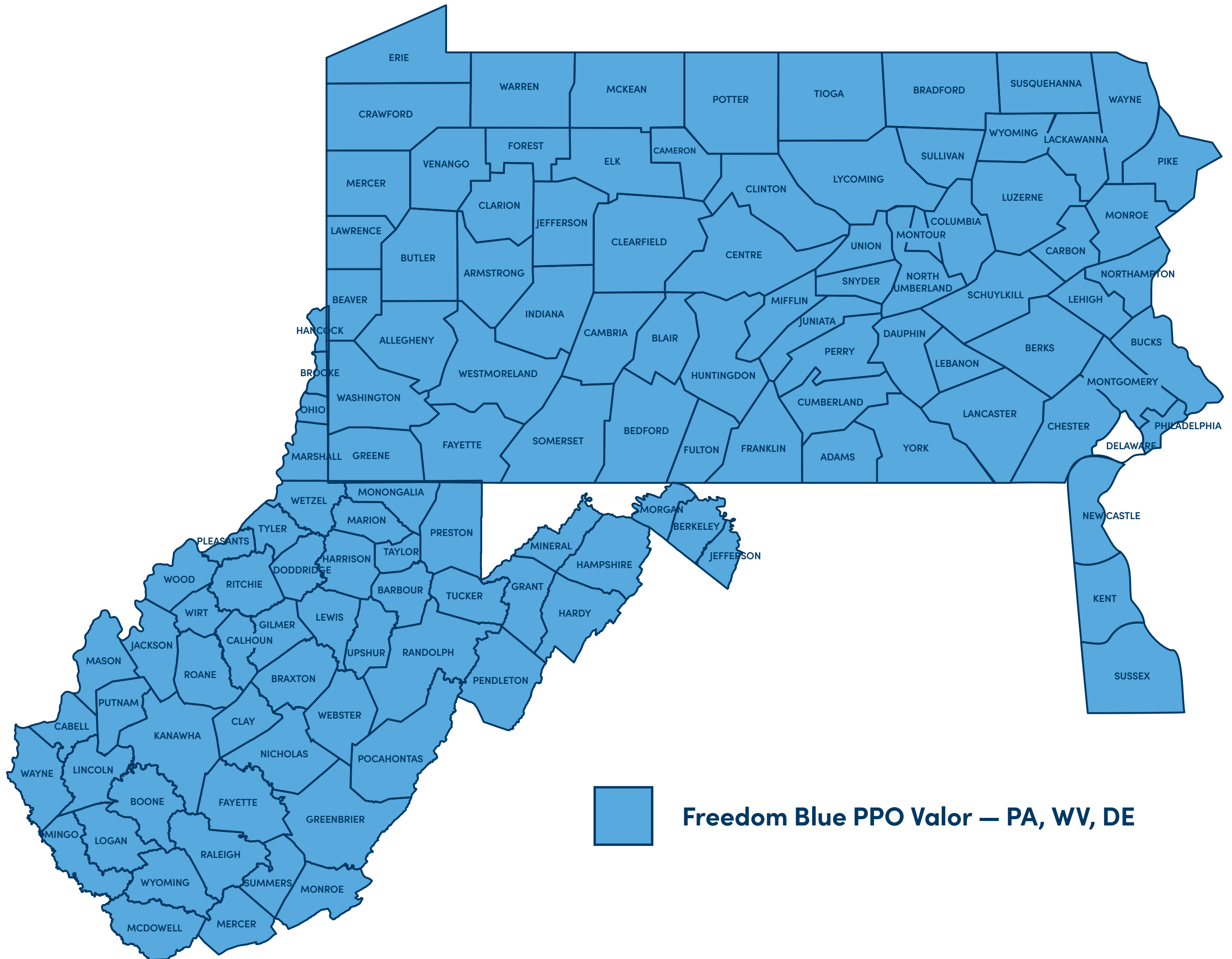
*Pricing is subject to CMS approval

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	20% Coinsurance IN	20% Coinsurance IN
Advanced Imaging	$200 Copay 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	N/A	
Emergency Room	$125 Copay	
Urgent Care	$55 Copay	
Inpatient Hospital Stay (COVID-19 cost share waiver has been 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 days 21 – 100. No yearly benefit period maximum.	
Home Health	$0 Copay IN	
Diabetic Supplies and Services	$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.).	
Durable Medical Equipment	$0 compression stockings, diabetic shoes/inserts; 20% all other items	
OTC	$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 from an inpatient hospital, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.	
Onduo	$0 Onduo Virtual Diabetes Program for Diabetes. Members can see an endocrinologist and receive a glucometer with an unlimited supply of test strips	
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 IN	
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $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)	$25 Copay IN; Benefit is carved out to Davis Vision (One every year)	
Routine Vision (Eyewear)	$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	$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 — $499 copay; TruHearing Premium — $799 copay	
Routine Dental	Office: $0 Copay IN (One every six months) Includes exam 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	Comprehensive maximum allowance of $2000	
Comprehensive Dental — Supplemental	Restorative, Endodontics, Prosthodontics, Oral/Maxillofacial Surgery: 50% Coinsurance IN. Periodontal cleanings/maintenance $0 Copay IN, all other periodontal services are covered at 50% IN. Adjunctive General Services: 50% Palliative, All others not coverd IN. See EOC for benefit limits.	
Medicare Covered Chiropractic	$15 Copay IN	
Routine Chiropractic	$15 Copay IN (12 per plan year)	$15 Copay IN (12 per plan year)
Medicare Covered Podiatry	$35 Copay IN	$26 Copay IN
Routine Podiatry	$35 Copay IN (three visits)	$26 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	Cardiac Rehab: $15 Copay IN Partial Hospital: $55 Copay IN Outpatient Blood: $0 Copay IN	Cardiac Rehab: $10 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. 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: $8, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Retail: Tier 1: $7, Tier 2: $13, 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% 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 to 31-days supply)	Preferred Mail: Tier 1: $0, Tier 2: $20, Tier 3: 25%, Tier 4: 50%, Tier 5: 33% Standard Mail: Tier 1: $17.50, Tier 2: $32.50, 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% 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 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

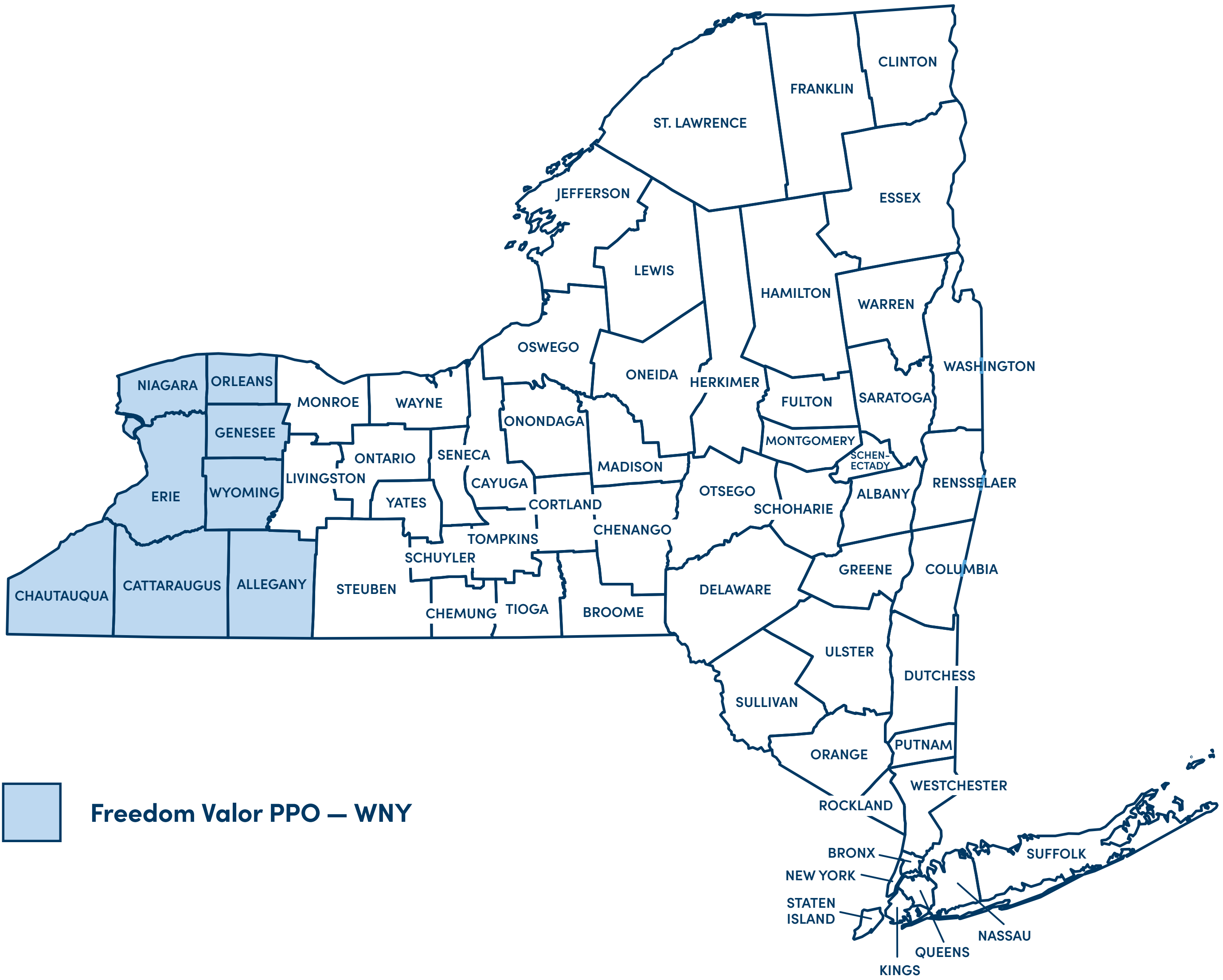
FOREVER BLUE 770 PPO
$198
$0
Network: $6,700; Combined: $10,000
$0-$5 Copay IN; 25% Coinsurance OON
$22 Copay IN; 25% Coinsurance OON
$5 lab Copay IN; $5 copay OON; $40 diagnostic test copay IN; 25% Coinsurance OON
$5 lab Copay IN; $5 copay OON; $40 diagnostic test copay IN; 25% Coinsurance OON
$40 Copay IN; 25% Coinsurance OON
20% Coinsurance IN; 25% Coinsurance OON
$150 Copay 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; Facility: $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: $0 Copay IN (One every year); $0 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

	FREEDOM BLUE PPO VALOR	
Monthly Plan Premium	$0	$0
Part B Premium Buyback	WPA/CPA/NEPA: $75	SEPA: $60
Out-of-Pocket Maximum	Network: $6,000; Combined: $8,950	Network: $6,000; Combined: $8,950
PCP Office Visit	$0 Copay IN; $0 Copay OON	$0 Copay IN; $0 Copay OON
Specialist Office Visit	$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON
Lab and Diagnostic Tests (Phys Office or Freestanding Lab)	$0 Copay IN; $35 Copay OON	$0 Copay IN; $35 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	$0 Copay IN; $35 Copay OON	$0 Copay IN; $35 Copay OON
X-rays	$20 Copay IN; $35 Copay OON	$20 Copay IN; $35 Copay OON
Radiation Therapy	$60 Copay IN; $80 Copay OON	$60 Copay IN; $80 Copay OON
Advanced Imaging	$225 Copay IN; $325 Copay OON	$225 Copay IN; $325 Copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON
Medicare Covered Acupuncture	$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON
Outpatient Occupational Therapy	$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON
Outpatient Mental Health	$5 Copay IN; $35 Copay OON	$5 Copay IN; $35 Copay OON
Outpatient Substance Abuse	$5 Copay IN; $35 Copay OON	$5 Copay IN; $35 Copay OON
Outpatient Surgical	ASC: $195 Copay IN; $325 Copay OON Facility: $245 Copay IN; $375 Copay OON	ASC: $200 Copay IN; $325 Copay OON Facility: $250 Copay IN; $375 Copay OON
Ambulance	Emergent/Non-Emergent: $250 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $250 IN Non-Emergent: 30% Coinsurance OON
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 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.
Emergency Room	$125 Copay	$125 Copay
Urgent Care	$50 Copay	$40 Copay
Inpatient Hospital Stay	$275/admit IN; $395/admit OON	$300/admit IN; $395/admit OON
Inpatient Psychiatry Stay	$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
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	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
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON	20% Coinsurance IN; 30% Coinsurance OON
OTC	$100 Allowance Once Per Quarter	$100 Allowance Once Per Quarter
Flex Card	N/A	N/A
Meal Benefit	N/A	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. 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	32 credits per month; no rollover of credits
Additional Telehealth Services	Services covered with applicable cost share listed for in-person 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	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)	$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON
Routine Vision (Office Visit)	$0 Copay IN; $50 Copay OON (One Every Year)	$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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.	
Medicare Covered Hearing Exam	$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON
Routine Hearing Exam	$0 Copay IN; $0 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	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, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One Every Year)	
Medicare Covered Comprehensive Dental	$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON
Dental Allowance - Preventive and/or Comprehensive	Combined maximum allowance of $3,000	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.	$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.
Medicare Covered Chiropractic	$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON
Routine Chiropractic	$15 Copay IN; $35 Copay OON (Eight visits)	$15 Copay IN; $35 Copay OON (Eight visits)
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
PART D DRUGS		
Prescription Drug Coverage	N/A	

FREEDOM BLUE PPO VALOR		FREEDOM VALOR PPO
$0	$0	$0
WV: $75	DE: $70	WNY: $50
Network: $6,000; Combined: $8,950	Network: $6,000; Combined: $8,950	Network: $6,700; Combined: $10,000
$0 Copay IN; $0 Copay OON	$0 Copay IN; $0 Copay OON	$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 $45 diagnostic test Copay IN; 50% Coinsurance OON
$20 Copay IN; $35 Copay OON	$20 Copay IN; $35 Copay 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; 50% Coinsurance OON
$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON	$35 Copay IN; 50% Coinsurance OON
$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay 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; 30% Coinsurance OON	$0/day (days 1 – 20); $214/day (days 21 – 100) IN; 30% Coinsurance OON	IN: $0 per day for days 1 – 20; $214.00 per day for days 21 – 100, 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% 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	$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
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
N/A	N/A	$0 for one meal per day for 7 days upon discharge from an inpatient hospital, SNF or Inpatient Psych 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	32 credits per month; no rollover of credits	32 credits per month; no rollover of credits
Services covered with applicable cost 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	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
20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN; $35 Copay OON		
$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 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 in full. IN/OON: A $200 benefit maximum applies to non-standard frames or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		$100 Allowance for routine eyewear
$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON	$35 Copay IN; 50% Coinsurance OON
$0 Copay IN; $0 Copay OON (One Every Year)	$0 Copay IN; $0 Copay OON (One Every Year)	$45 Copay (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 — $699 copay; TruHearing Premium — $999 copay
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)		Office: $0 Copay IN; $0 Copay OON (One Every Six Months) Includes exam, cleaning and flouride treatment X-Ray: $0 Copay IN (One Every Year); $0 Copay OON
$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 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 OON. 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 0% Coinsurance, all others: 50% Coinsurance IN; All services: 50% Coinsurance OON. See EOC for benefit limits.
$15 Copay IN; $35 Copay OON	$15 Copay IN; $35 Copay OON	$15 Copay IN; 50% Coinsurance OON
$15 Copay IN; $35 Copay OON (Eight visits)	$15 Copay IN; $35 Copay OON (Eight visits)	$15 Copay IN (6 per plan year); 50% Coinsurance OON
$10 Copay IN; $10 Copay OON	$10 Copay IN; $10 Copay OON	$35 Copay IN; 50% Coinsurance OON
$10 Copay IN; $10 Copay OON (10 visits)	$10 Copay IN; $10 Copay OON (10 visits)	$35 Copay IN; 50% Coinsurance OON (3 visits)
$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 30% Coinsurance OON	Cardiac Rehab: $15 Copay IN; 50% Coinsurance OON Partial Hospital: $55 copay IN; 50% Coinsurance OON Outpatient Blood: $0 Copay IN; 50% Coinsurance OON
PART D DRUGS		
N/A		

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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

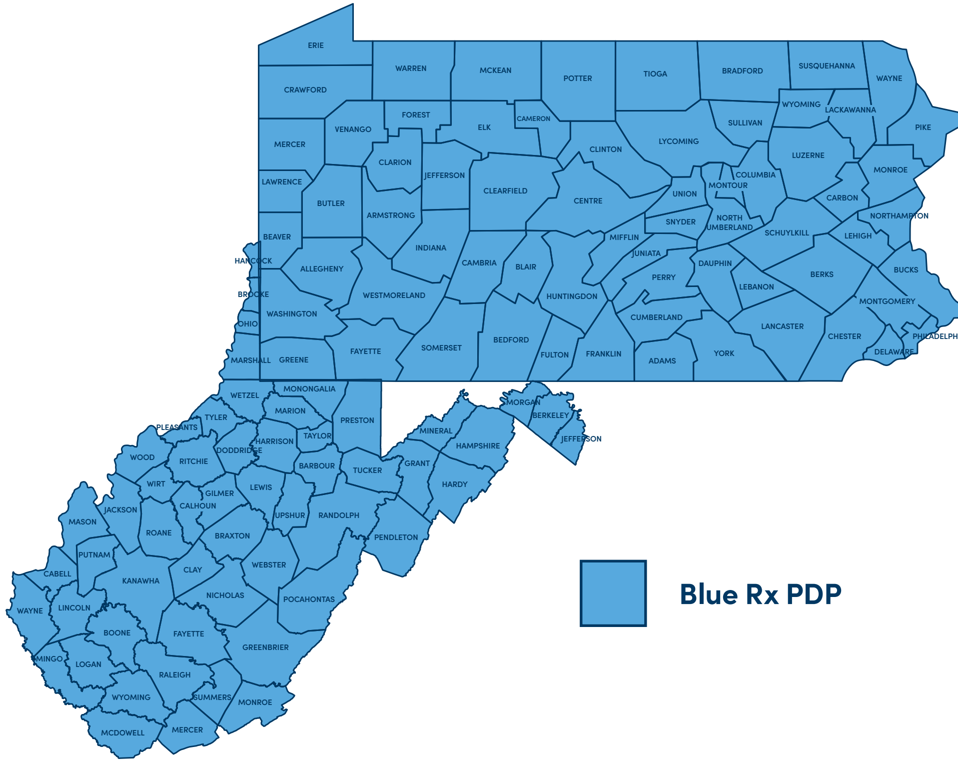
Part B giveback	
WNY	$75

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. 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: $0 Pref. Gen, $7 Generic, 24% Pref. Brand, 40% Non-pref. Drug, 25% Specialty Standard Retail: $5 Pref. Gen, $12 Generic, 24% Pref. Brand, 50% Non-pref. Drug, 25% Specialty	Preferred Retail: $0 Pref. Gen, $5 Generic, 25% Pref. Brand, 49% Non-pref. Drug, 33% Specialty Standard Retail: $4 Pref. Gen, $10 Generic, 25% Pref. Brand, 49% Non-pref. Drug, 33% Specialty
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: Tier 1: $0, Tier 2: $17.50, Tier 3: 24%, Tier 4: 40%, Tier 5: 25% Standard Mail: Tier 1: $10, Tier 2: $30, Tier 3: 24%, Tier 4: 50%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $12.50, Tier 3: 25%, Tier 4: 49%, Tier 5: 33% 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	

Pricing is subject to CMS approval

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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 Call℠:** 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 health-related 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 high-touch 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.

*Pending BCBSA approval

PRODUCTS AND PRICING BY COUNTY

D-SNP

Highmark Wholecare Medicare Assured Diamond and Ruby

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
FOREST
CAMERON
WYOMING
LACKAWANNA
PIKE
MERCER
VENANGO
ELK
SULLIVAN
LYCOMING
CLINTON
LUZERNE
CLARION
JEFFERSON
MONROE
LAWRENCE
CLEARFIELD
COLUMBIA
MONTOUR
BUTLER
CENTRE
UNION
CARBON
ARMSTRONG
NORTH UMBERLAND
NORTHAMPTON
SNYDER
BEAVER
INDIANA
MIFFLIN
SCHUYLKILL
LEHIGH
JUNIATA
CAMBRIA
BLAIR
DAUPHIN
ALLEGHENY
PERRY
BERKS
BUCKS
LEBANON
WESTMORELAND
HUNTINGDON
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
CHESTER
PHILADELPHIA
BEDFORD
FAYETTE
SOMERSET
DELAWARE
GREENE
FULTON
FRANKLIN
YORK
ADAMS

Pricing is subject to CMS approval

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

	HIGHMARK WHOLECARE MEDICARE ASSURED DIAMOND	HIGHMARK WHOLECARE MEDICARE ASSURED RUBY
Monthly Plan Premium	$0	$0
Out-of-Pocket Maximum	$9,350 OOP Max	$6,700 OOP Max
PCP Office Visit	$0 Copay	$0 Copay
Specialist Office Visit	$0 Copay	$25 Copay
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	$0 Copay and Authorization required	$0 Copay and Authorization required
Lab and Diagnostic Tests (Outpatient Facility)	$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 Copay	$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 for Individual and Group Sessions
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 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 cannot 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
OTC	$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.
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 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.
Personal Emergency Response System (PERS)	Benefit coordinated through Highmark Wholecare Health Case Management 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 bifocals, 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)	$0 Copay; Two Hearing Aids every year; TruHearing Advanced — $0 Copay	$0 Copay; Two Hearing Aids every three years; TruHearing Advanced — $0 Copay
Routine Dental	$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.	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 or an immediate denture, and denture repairs	$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 prophylaxis 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 an 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	Cost sharing waived for all Part D drugs across all benefit phases	Cost sharing waived for all Part D drugs across all benefit phases

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

**Pricing is subject to CMS approval*

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

	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 Copay for Individual and Group Sessions
Outpatient Substance Abuse	$0 Copay
Medicare Covered Acupuncture	$0 Copay and Authorization required
Ambulatory Surgical Services	$0 Copay 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	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.
Home and Bathroom Safety Devices and Modifications	$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.
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 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	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, lenticular. The following lens 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	
Part D Reduced Cost Sharing	Cost sharing waived for all Part D drugs across all benefit phases

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 non-emergency 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.

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PRODUCTS AND PRICING BY COUNTY

ACA Individual Market

WPA

ERIE
WARREN
MCKEAN
POTTER
CRAWFORD
FOREST
CAMERON
ELK
VENANGO
MERCER
CLARION
JEFFERSON
LAWRENCE
CLEARFIELD
BUTLER
CENTRE
ARMSTRONG
BEAVER
INDIANA
CAMBRIA
ALLEGHENY
BLAIR
WESTMORELAND
HUNTINGDON
WASHINGTON
BEDFORD
FAYETTE
SOMERSET
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

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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

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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

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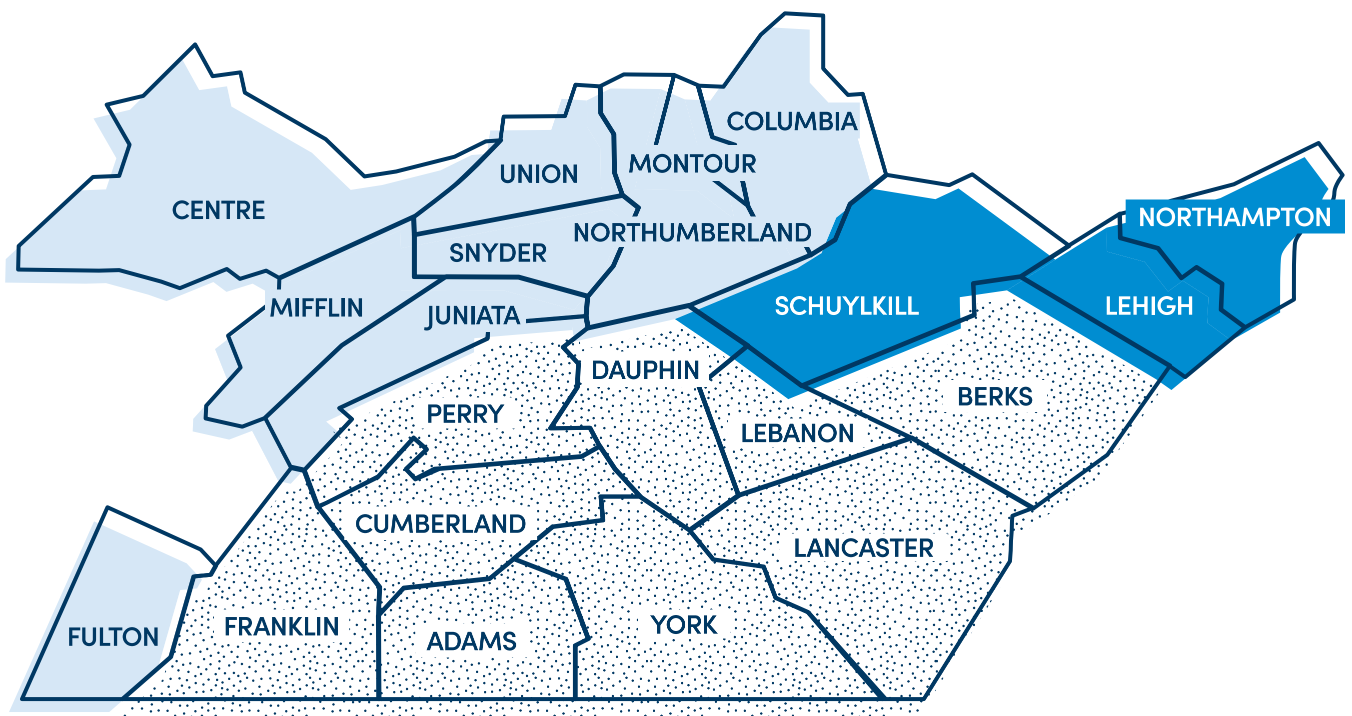
CPA



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

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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

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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

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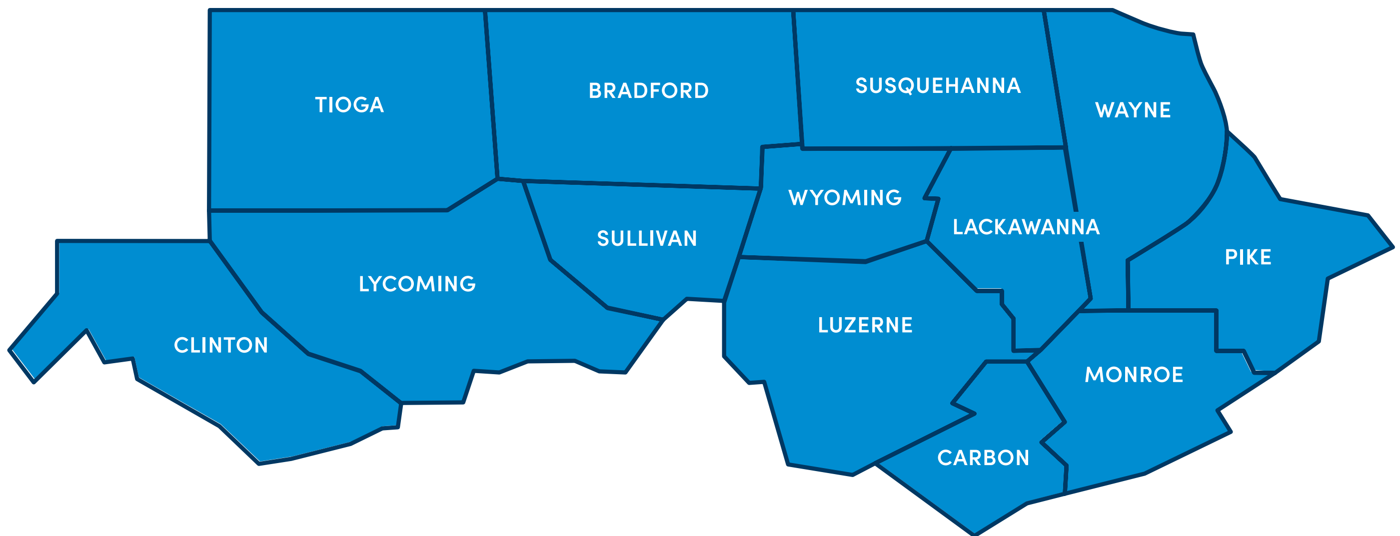
NEPA

my Priority Blue Flex PPO



Coverage Level	Catastrophic 9200 — 3 Free PCP Visits	Bronze 8900	Bronze 7400 HSA — Custom Drug Benefit	Bronze 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 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 (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

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NEPA, cont.

Coverage Level	Silver 7000	Silver 3500 (Off Exchange only)	Premier Silver 0	Gold 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: $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	Enhanced: $70 copay Standard: $75 copay	Enhanced: $50 copay Standard: $70 copay	Enhanced: $70 copay Standard: $90 copay	Enhanced: $20 copay Standard: $30 copay
Specialist Visit	Enhanced: $70 copay Standard: $75 copay	Enhanced: $50 copay Standard: $70 copay	Enhanced: $70 copay Standard: $90 copay	Enhanced: $20 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 (Lab/X-ray)	Enhanced: $75 copay Standard: $85 copay	Enhanced: $55 copay Standard: $75 copay	Enhanced: $70 copay Standard: $90 copay	Enhanced: $35 copay Standard: $50 copay
Urgent Care	Enhanced: $100 copay Standard: $100 copay	Enhanced: $100 copay Standard: $100 copay	Enhanced: $100 copay Standard: $100 copay	Enhanced: $40 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 0	Gold 1500	Gold 1700 HSA
Plan Availability	**my Priority Blue Flex PPO**	**my Priority Blue Flex PPO**	**my Priority Blue Flex 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	Enhanced: $15 copay Standard: $25 copay	Enhanced: $35 copay Standard: $40 copay	Enhanced: $20 copay after deductible Standard: $25 copay after deductible
Specialist Visit	Enhanced: $15 copay Standard: $25 copay	Enhanced: $35 copay Standard: $40 copay	Enhanced: $20 copay after deductible 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 (Lab/X-ray)	Enhanced: $35 copay Standard: $50 copay	Enhanced: $40 copay Standard: $50 copay	Enhanced: $20 copay after deductible Standard: $25 copay after deductible
Urgent Care	Enhanced: $30 copay Standard: $30 copay	Enhanced: $70 copay Standard: $70 copay	Enhanced: $40 copay after deductible Standard: $40 copay after deductible
Emergency Services	Enhanced: $280 copay Standard: $280 copay	Enhanced: $350 copay Standard: $350 copay	$175 copay after deductible 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

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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

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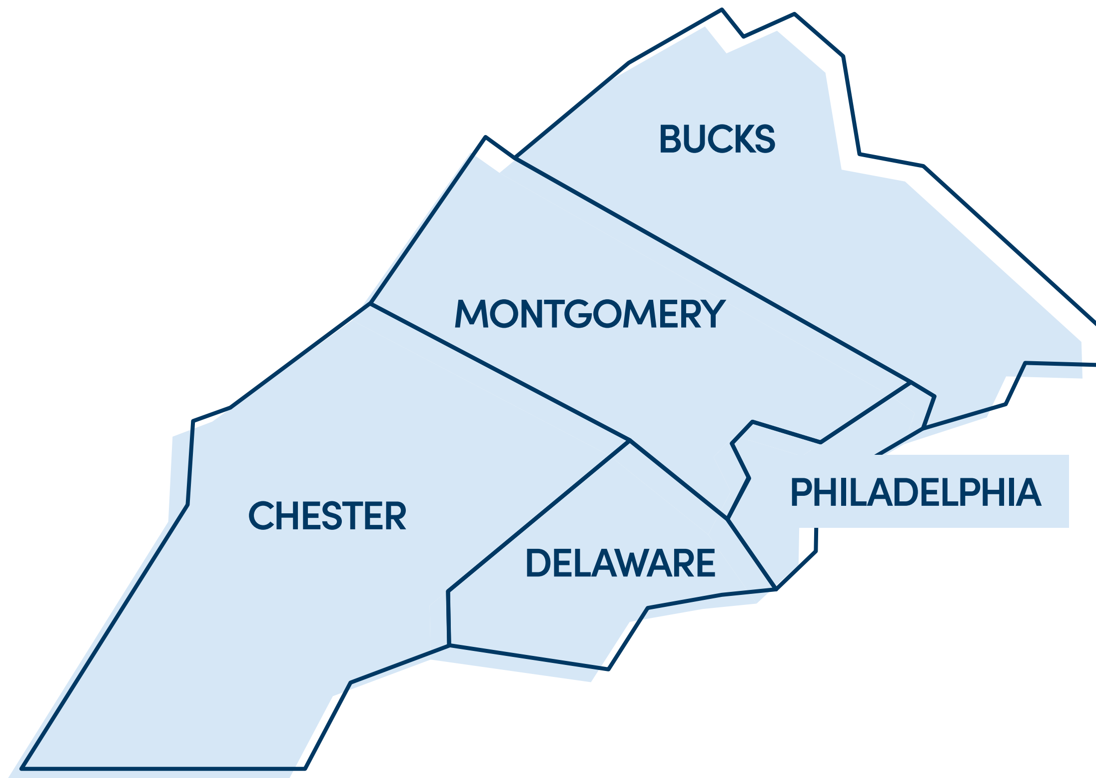
SEPA



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

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SEPA, cont.

Coverage Level	Silver 7000	Silver 3500 (Off Exchange only)	Premier Silver 0	Gold 0
Plan Availability	**my Blue Access PPO**	**my Blue Access PPO**	**my Blue Access PPO**	**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

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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

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HANCOCK
BROOKE
OHIO
MARSHALL
WETZEL
MONONGALIA
MARION
PRESTON
PLEASANTS
TYLER
HARRISON
TAYLOR
MINERAL
MORGAN
BERKELEY
HAMPSHIRE
JEFFERSON
WOOD
DODDRIDGE
RITCHIE
BARBOUR
TUCKER
GRANT
HARDY
WIRT
LEWIS
GILMER
UPSHUR
RANDOLPH
JACKSON
CALHOUN
MASON
BRAXTON
ROANE
PENDLETON
PUTNAM
WEBSTER
CABELL
CLAY
KANAWHA
NICHOLAS
POCAHONTAS
LINCOLN
WAYNE
BOONE
FAYETTE
GREENBRIER
LOGAN
RALEIGH
MINGO
SUMMERS
WYOMING
MONROE
MCDOWELL
MERCER

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

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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**	**my Blue Access PPO**	**my Blue Access PPO**	**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

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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

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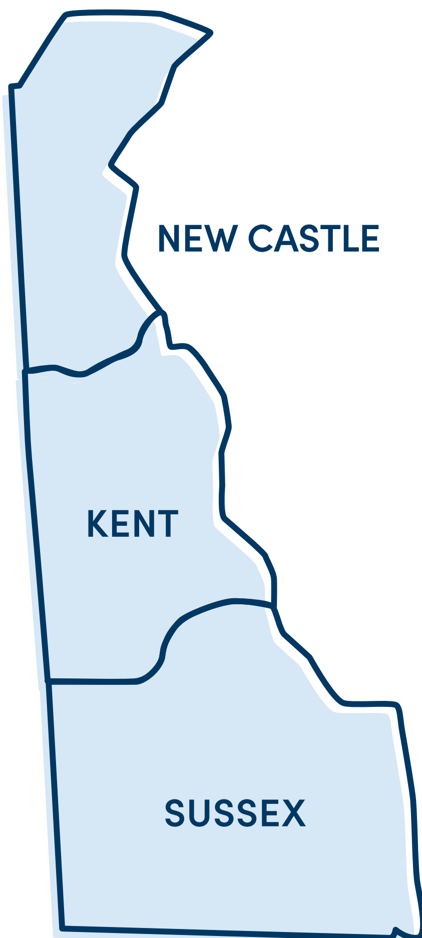
DE



DE, 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	$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

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DE, 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	$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

DE, cont.

Coverage Level	Standard Gold 1500	Gold 0	Premier Gold 0	Gold 1700 HSA
Plan Availability	**my Blue Access PPO**	**my Blue Access PPO**	**my Blue Access PPO**	**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

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DE, cont.

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

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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

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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

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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

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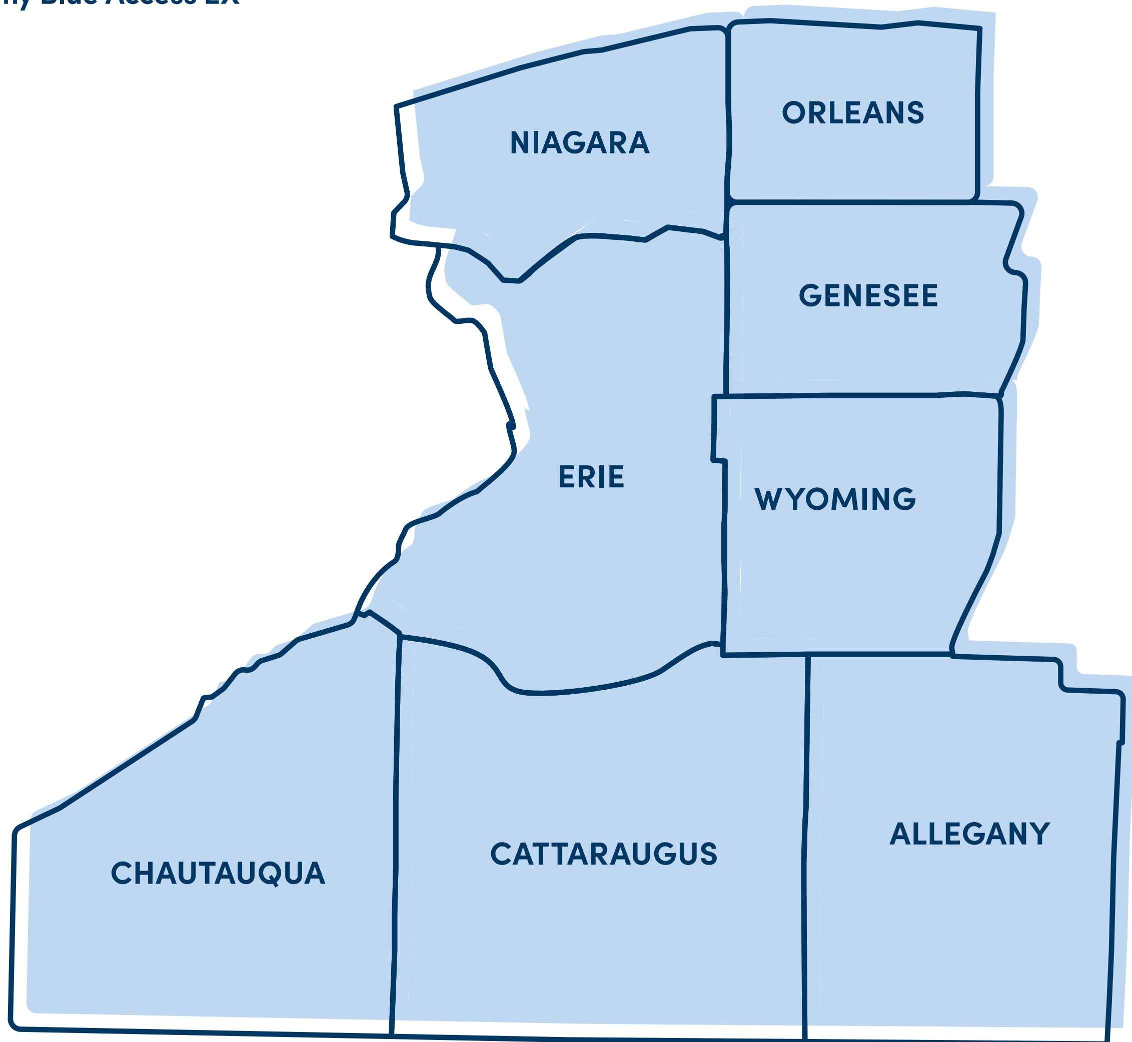
WNY



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

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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

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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

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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.

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

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 high-touch 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.

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