2026

Product Guide

HIGHMARK MEDICARE ADVANTAGE, D-SNP, AND ACA INDIVIDUAL MARKET

HIGHMARK

Because Life.™

Contents

All About the BlueCard® Program

The Blue Cross Blue Shield Association's BlueCard® Program connects independent Blue Plans across the country, with access to the largest physician and hospital networks in the U.S. and over 1.7 million providers, including 95% of all hospitals.* When members travel, they are covered in 190 countries through the Blue Cross Blue Shield Global® Core program.* BlueCard® allows in-network access to routine, urgent, and emergency care from BlueCard® participating providers.

However, certain services may still require members to work with their BlueCard® participating provider to obtain prior authorization. To determine if care requires prior authorization, the member can call Member Service at the number on the back of their ID card. The level of coverage depends on the chosen plan.

Under this program, many out-of-state facilities are in network due to our partnerships with them.

Note: The BlueCard® program applies to PPO plans for Medicare Advantage and all plans for Individual ACA except Together Blue EPO, where only emergency coverage is included.

The best way to find a BlueCard® facility is to call **800-810-BLUE** or visit the BlueCard® Doctor and National Hospital Finder website at **bcbs.com**.

* According to the Blue Cross Blue Shield Association.

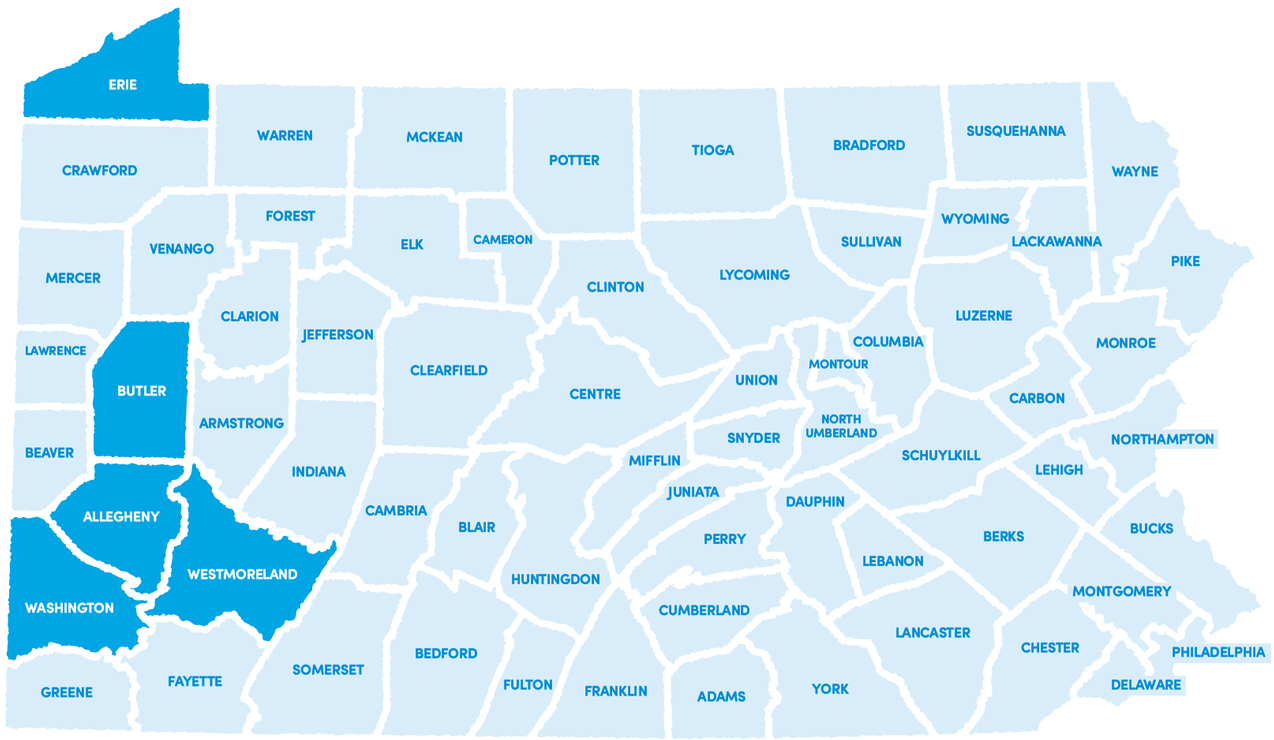
PRODUCTS AND PRICING BY COUNTY

Medicare Advantage

2026 Highmark Medicare Advantage Products at a glance

Product Name	Available in (products and pricing by county)	HMO/PPO
Complete Blue HMO	WPA	HMO
Complete Blue PPO	WPA, CPA, NEPA, SEPA, DE, and WV	PPO
Community Blue Medicare PPO	CPA, NEPA	PPO
Community Blue Medicare Plus PPO	NEPA	PPO
Community Blue Medicare HMO	WPA, CPA, NEPA, and WNY	HMO
Freedom Blue PPO	WPA, CPA, NEPA, SEPA, DE, and WV	PPO
Security Blue HMO-POS	WPA	HMO-POS
Together Blue Medicare HMO	WPA	HMO
Senior Blue	WNY, NENY	HMO
Forever Blue	WNY, NENY	PPO
Freedom	WNY	PPO
Blue Rx PDP	PA, WV	PDP

Together Blue Medicare HMO Signature — WPA



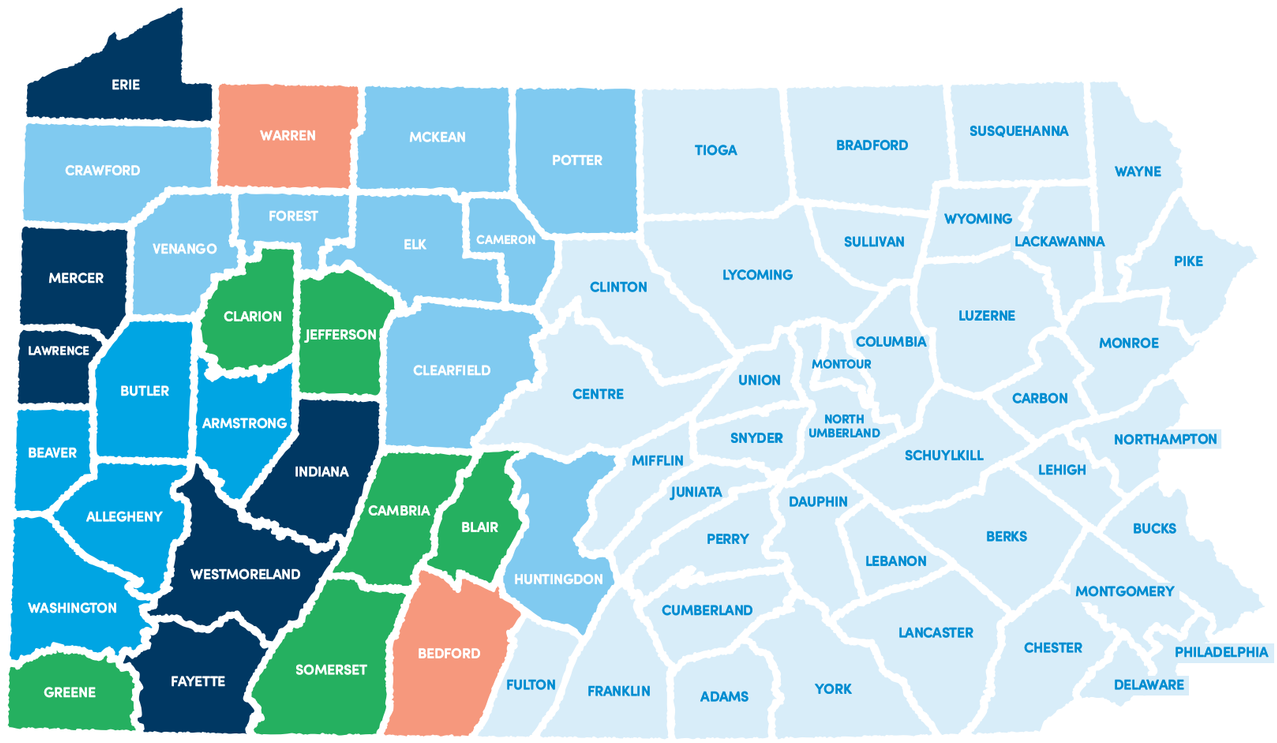
Together Blue Medicare HMO Signature

**Pricing is subject to CMS approval*

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

Monthly Plan Premium	$0
Part B Premium Giveback	$38
Out-of-Pocket Maximum	Network: $4,900 OOP Max; Combined: N/A
PCP Office Visit	$0 Copay
Specialist Office Visit	$10 Copay
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 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	$10 Copay
Medicare Covered Acupuncture	$10 Copay
Outpatient Occupational Therapy	$10 Copay
Outpatient Mental Health and Psychiatric Therapy	$30 Copay
Outpatient Substance Abuse and Opioid Treatment Services	$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	$130 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	$200/admit
Inpatient Psychiatry Stay	$325/day (days 1 – 3), $0/day (days 4 – 90)
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.
Healing at Home	DME: $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF. Non-Skilled Care: $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.
OTC Catalog	$195 Allowance Once Per Quarter
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full
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
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)	$10 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 or a $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	$10 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay (One every year)
Medicare Covered Comprehensive Dental	$10 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	$10 Copay
Routine Podiatry	$10 Copay (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45,Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Signature — WPA



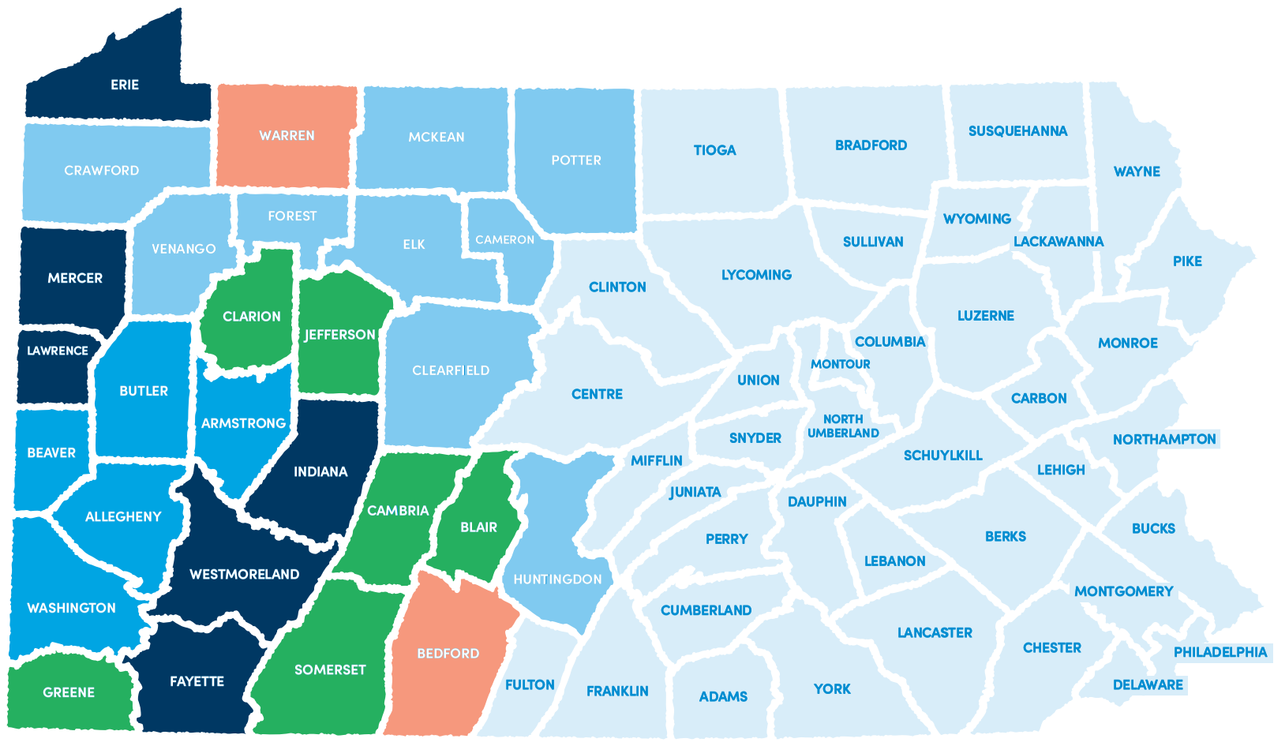
Region 1 | Region 2 | Region 3 | Region 4 | Region 5

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 2 / REGION 3 / REGION 4 / REGION 5
Monthly Plan Premium	$0
Part B Premium Giveback	$0
Out-of-Pocket Maximum	Network: $6,500 OOP Max; Combined: N/A
PCP Office Visit	$0 Copay
Specialist Office Visit	Region 1, 2: $20 Copay; Region 3, 4: $25 Copay; Region 5: $30 Copay
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay
X-rays	$20 Copay
Radiation Therapy	$60 Copay
Advanced Imaging	Region 1, 4, 5: $195 Copay; Region 2, 3: $210 Copay
Preventive/Screening	Covered in Full (Office visit copay may apply)
Outpatient Physical and Speech Therapy	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Medicare Covered Acupuncture	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Outpatient Occupational Therapy	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Outpatient Mental Health and Psychiatric Therapy	$40 Copay
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay
Outpatient Surgical	ASC: Region 1, 4, 5: $175 Copay; Region 2, 3: $225 Copay Facility: Region 1, 4, 5: $245 Copay; Region 2, 3: $275 Copay
Ambulance	Region 1, 3: $265 Copay; Region 2, 4: $375 Copay; Region 5: $300 Copay
Transportation	$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	$130 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	Region 1: $275/admit; Region 2, 3, 4: $300/admit; Region 5: $195/day (days 1 – 5), $0/day (days 6 – 90)
Inpatient Psychiatry Stay	$425/day (days 1 – 3), $0/day (days 4 – 90)
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.
Healing at Home	DME: Region 1: $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF; Region 2, 3, 4, 5: Not Covered Non-Skilled Care: Region 1: $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; Region 2, 3, 4, 5: Not Covered
OTC Catalog	Region 1, 2, 3: $95 Allowance Once Per Quarter; Region 4: $70 Allowance Once Per Quarter; Region 5: $40 Allowance Once Per Quarter
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full
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
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)	Region 1, 2: $20 Copay; Region 3, 4: $25 Copay; Region 5: $30 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 $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	Region 1, 2: $20 Copay; Region 3, 4: $25 Copay; Region 5: $30 Copay
Routine Hearing Exam	$10 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay (One every year)
Medicare Covered Comprehensive Dental	Region 1, 2: $20 Copay; Region 3, 4: $25 Copay; Region 5: $30 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	Region 1, 2: $20 Copay; Region 3, 4: $25 Copay; Region 5: $30 Copay
Routine Podiatry	Region 1, 2: $20 Copay (Four visits); Region 3, 4: $25 Copay (Four visits); Region 5: $30 Copay (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy

Complete Blue HMO Distinct — WPA



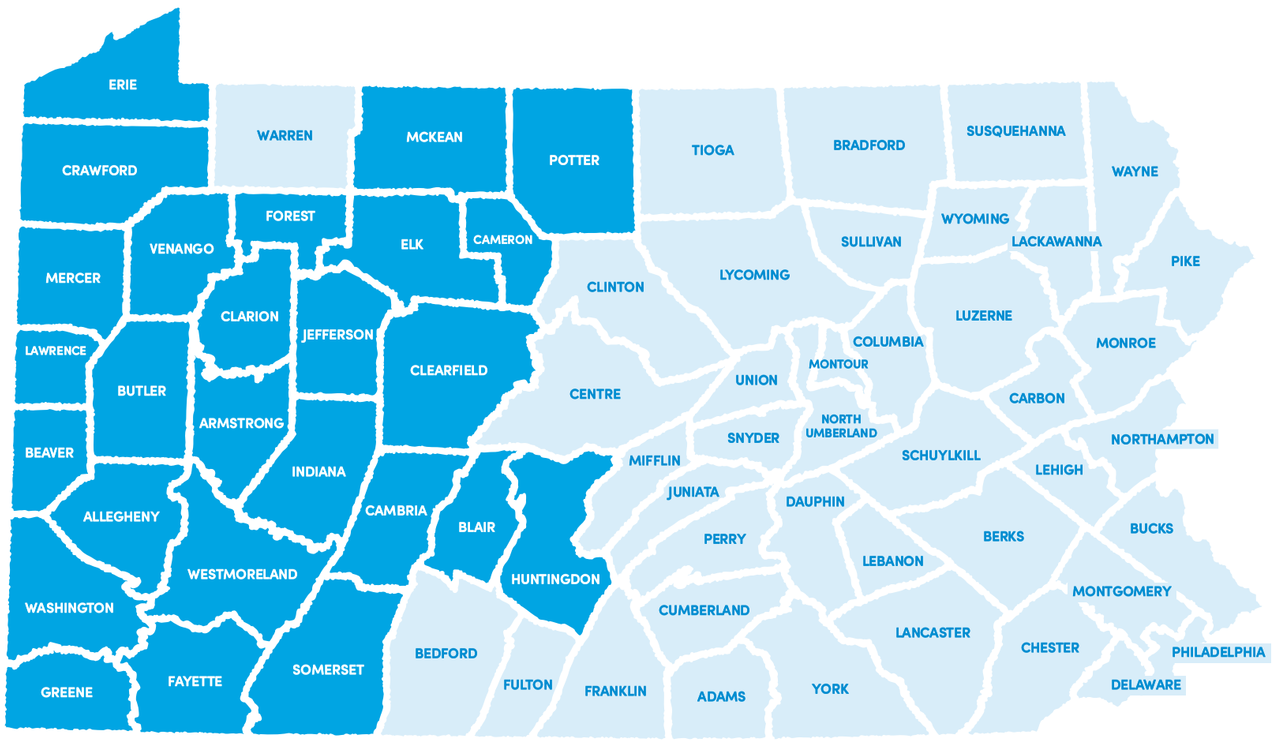
Region 1 **Region 2** **Region 3** **Region 4** **Region 5**

**Pricing is subject to CMS approval*

Complete Blue HMO Distinct — WPA (Products and pricing by county)

	REGION 1 / REGION 2 / REGION 3 / REGION 4 / REGION 5
Monthly Plan Premium	Region 1, 2, 3: $20; Region 4, 5: $25
Part B Premium Giveback	Region 1: $5; Region 2: $7; Region 3: $8; Region 4, 5: $0
Out-of-Pocket Maximum	Network: $5,900 OOP Max; Combined: N/A
PCP Office Visit	$0 Copay
Specialist Office Visit	Region 1, 2, 3: $20 Copay; Region 4, 5: $25 Copay
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay
X-rays	$20 Copay
Radiation Therapy	$50 Copay
Advanced Imaging	Region 1: $150 Copay; Region 2, 3: $165 Copay; Region 4, 5: $195 Copay
Preventive/Screening	Covered in Full (Office visit copay may apply)
Outpatient Physical and Speech Therapy	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Medicare Covered Acupuncture	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Outpatient Occupational Therapy	Region 1, 2: $15 Copay; Region 3, 4, 5: $20 Copay
Outpatient Mental Health and Psychiatric Therapy	$30 Copay
Outpatient Substance Abuse and Opioid Treatment Services	$30 Copay
Outpatient Surgical	ASC: $175 Copay Facility: $245 Copay
Ambulance	Region 1, 2, 3: $200 Copay; Region 4: $345 Copay; Region 5: $355 Copay
Transportation	$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	$130 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	Region 1: $275/admit; Region 2, 3, 4: $300/admit; Region 5: $175/day (days 1 – 5), $0/day (days 6 – 90)
Inpatient Psychiatry Stay	$225/admit
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.
Healing at Home	DME: Region 1: $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF; Region 2, 3, 4, 5: Not Covered Non-Skilled Care: Region 1: $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; Region 2, 3, 4, 5: Not Covered
OTC Catalog	Region 1: $80 Allowance Once Per Quarter; Region 2, 3: $90 Allowance Once Per Quarter; Region 4: $75 Allowance Once Per Quarter; Region 5: $40 Allowance Once Per Quarter
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full
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
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)	Region 1, 2, 3: $20 Copay; Region 4, 5: $25 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 $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	Region 1, 2, 3: $20 Copay; Region 4, 5: $25 Copay
Routine Hearing Exam	$10 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay (One every year)
Medicare Covered Comprehensive Dental	Region 1, 2, 3: $20 Copay; Region 4, 5: $25 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 (Eight visits)
Medicare Covered Podiatry	Region 1, 2, 3: $20 Copay; Region 4, 5: $25 Copay
Routine Podiatry	Region 1, 2, 3: $20 Copay (10 visits); Region 4, 5: $25 Copay (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy

Complete Blue PPO Merit — WPA



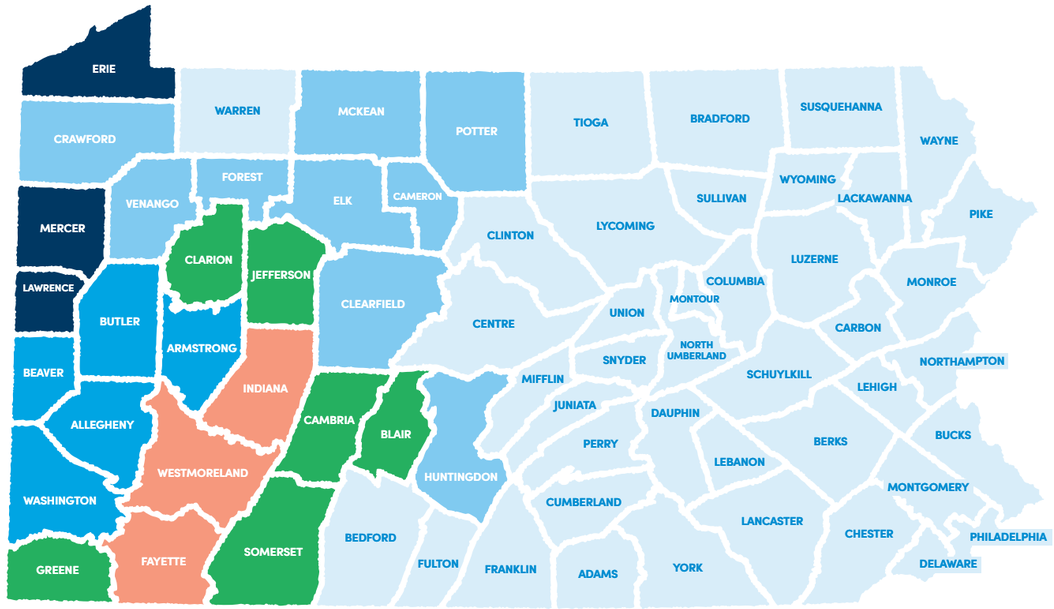
Complete Blue PPO Merit

**Pricing is subject to CMS approval*

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

Monthly Plan Premium	$0
Part B Premium Giveback	$90
Out-of-Pocket Maximum	Network: $8,300 OOP Max;Combined: $8,950 OOP Max
Medical Deductible (+ indicates deductible applies before cost sharing)	$200
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON +
Specialist Office Visit	$40 Copay IN; 40% Coinsurance OON +
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay (Lab) IN, $0 Copay (Diagnostic) IN +; 40% Coinsurance OON +
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay (Lab) IN, $10 Copay (Diagnostic) IN +; 40% Coinsurance OON +
X-rays	$20 Copay IN +; 40% Coinsurance OON + (Deductible does not apply to diagnostic mammograms IN)
Radiation Therapy	$60 Copay IN +; 40% Coinsurance OON +
Advanced Imaging	$300 Copay IN +; 40% Coinsurance OON +
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	$35 Copay IN +; 40% Coinsurance OON +
Medicare Covered Acupuncture	$35 Copay IN +; 40% Coinsurance OON +
Outpatient Occupational Therapy	$35 Copay IN +; 40% Coinsurance OON +
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN +; 40% Coinsurance OON +
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN +; 40% Coinsurance OON +
Outpatient Surgical	ASC: $325 Copay IN +; $475 Copay OON + (Deductible does not apply to diagnostic colonoscopy IN) Facility: $375 Copay IN +; $475 Copay OON + (Deductible does not apply to diagnostic colonoscopy IN)
Ambulance	Emergent/Non-Emergent: $340 Copay 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	$115 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	$400/day (days 1 – 5) IN, $0/day (days 6 – 90) IN +; $600/day (days 1 – 5), $0/day (days 6 – 90) OON +
Inpatient Psychiatry Stay	$400/day (days 1 – 5), $0/day (days 6 – 90) IN +; $475/day (days 1 – 5), $0/day (days 6 – 90) OON +
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON +
Durable Medical Equipment	20% Coinsurance IN +; 40% Coinsurance OON +
Healing at Home	Non-Skilled Care: Not Covered
OTC Catalog	Not Covered
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
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+
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% Coinsurance 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	$40 Copay IN; 40% Coinsurance OON+
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One every year)
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)
Medicare Covered Comprehensive Dental	$40 Copay IN; 40% Coinsurance OON+
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500
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 +; 40% Coinsurance OON +
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (four visits)
Medicare Covered Podiatry	$40 Copay IN; 40% Coinsurance OON +
Routine Podiatry	$40 Copay IN; 40% Coinsurance OON (four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services,: $0 Copay IN +; 40% Coinsurance OON + Outpatient Blood: $0 Copay IN +; 30% Coinsurance OON +
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy

Complete Blue PPO Signature — WPA



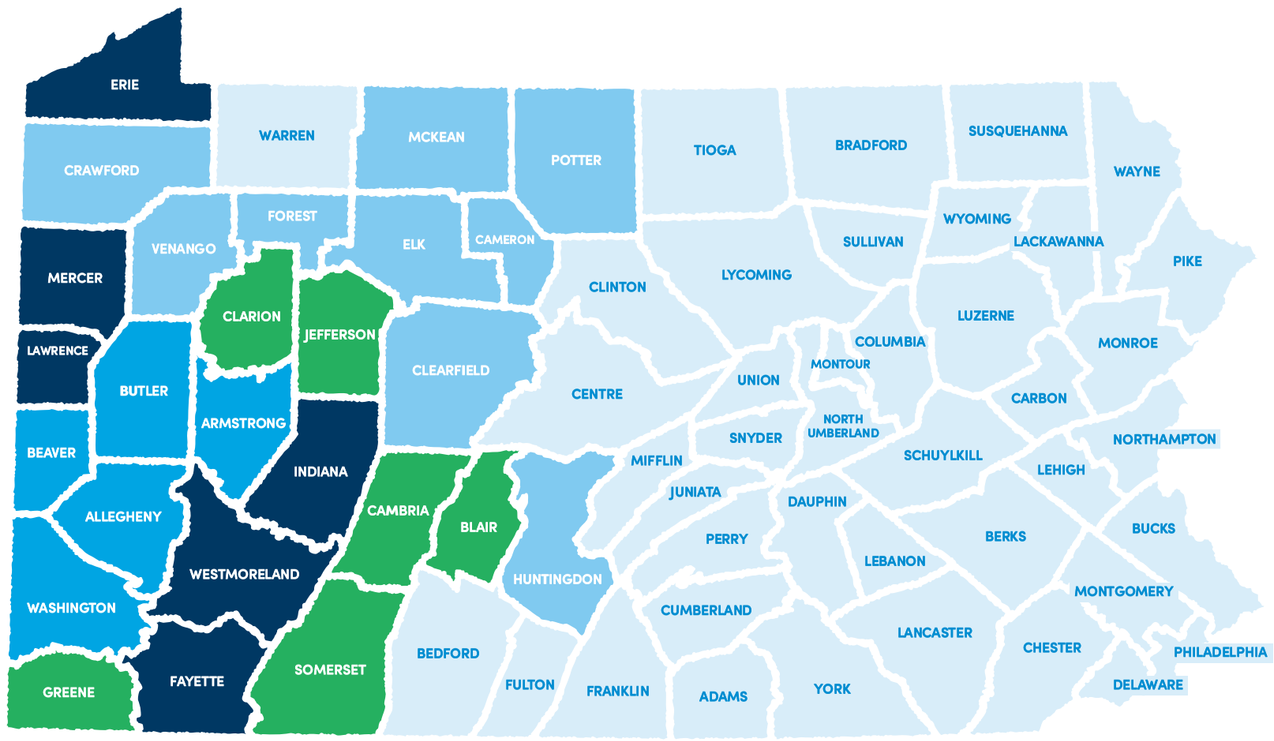
Region 1 | Region 2 | Region 3 | Region 4 | Region 5

**Pricing is subject to CMS approval*

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

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5
Monthly Plan Premium	$0		$0		
Part B Premium Giveback	$2	$9	$6	$0	$2
Out-of-Pocket Maximum	Network: $6,750 OOP Max/Combined: $8,950		Network: $6,750 OOP Max/Combined: $8,950	Network: $7550 OOP Max/Combined: $8,950	Network: $6,750 OOP Max/Combined: $8,950
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		$0 Copay IN; 40% Coinsurance OON		
Specialist Office Visit	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON		$0 Copay IN; 40% Coinsurance OON		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON		
X-rays	$20 Copay IN; 40% Coinsurance OON		$20 Copay IN; 40% Coinsurance OON		
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON		$60 Copay IN; 40% Coinsurance OON		
Advanced Imaging	$195 Copay IN; 40% Coinsurance OON		$200 Copay IN; 40% Coinsurance OON	$350 Copay IN; 40% Coinsurance OON	$200 Copay IN; 40% Coinsurance 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	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON		$40 Copay IN; 40% Coinsurance OON		
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON		$45 Copay IN; 40% Coinsurance OON		
Outpatient Surgical	ASC: $195 Copay IN; $325 Copay OON Facility: $245 Copay IN; $375 Copay OON		ASC: $215 Copay IN; $325 Copay OON Facility: $265 Copay IN; $375 Copay OON	ASC: $325 Copay IN; $400 Copay OON Facility: $375 Copay IN; $450 Copay OON	ASC: $205 Copay IN; $325 Copay OON Facility: $255 Copay IN; $375 Copay OON
Ambulance	Emergent/Non-Emergent: $325 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $260 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $430 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $430 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $425 Copay 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	$130 Copay		$130 Copay	$115 Copay	$130 Copay
Urgent Care	$40 Copay		$40 Copay		
Inpatient Hospital Stay	$165/day (days 1 – 5), $0/day (days 6 – 90) IN; $300/day (days 1 – 5), $0/day (days 6 – 90) OON	$175/day (days 1 – 5), $0/day (days 6 – 90) IN; $300/day (days 1 – 5), $0/day (days 6 – 90) OON	$195/day (days 1 – 5), $0/day (days 6 – 90) IN; $300/day (days 1 – 5), $0/day (days 6 – 90) OON	$275/day (days 1 – 7), $0/day (days 8 – 90) IN; $300/day (days 1 – 7), $0/day (days 8 – 90) OON	$175/day (days 1 – 5), $0/day (days 6 – 90) IN; $300/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); $218/day (days 21 – 100) IN; 30% Coinsurance OON		$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON		0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and Trividia, 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; 40% Coinsurance OON		
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON	20% Coinsurance IN; 40% Coinsurance OON	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON
Healing at Home	Not Covered		Not Covered		
OTC Catalog	$95 Allowance Once Per Quarter	$40 Allowance Once Per Quarter	$65 Allowance Once Per Quarter	$25 Allowance Once Per Quarter	$95 Allowance Once Per Quarter
Meal Benefit	Not Covered		Not Covered		
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
Additional Telehealth Services	Services covered with applicable cost share listed for in-person 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		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; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance 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.		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	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One Every Year)		$20 Copay IN; $20 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 (Two Every Year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One Every Year)		Office Visit: $0 Copay IN; 30% Coinsurance OON (Two Every Year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One Every Year)		
Medicare Covered Comprehensive Dental	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500		Combined maximum allowance of $2,500	Combined maximum allowance of $1,500	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.		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.	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.	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; 40% Coinsurance OON		$15 Copay IN; 40% Coinsurance OON		
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Four visits)	$15 Copay IN; 40% Coinsurance OON (Four visits)	$15 Copay IN; 40% Coinsurance OON (Four visits)	$15 Copay IN; 40% Coinsurance OON (Four visits)	$15 Copay IN; 40% Coinsurance OON (Four visits)
Medicare Covered Podiatry	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Routine Podiatry	$35 Copay IN; 40% Coinsurance OON (Four visits)	$30 Copay IN; 40% Coinsurance OON (Four visits)	$40 Copay IN; 40% Coinsurance OON (Four visits)	$50 Copay IN; 40% Coinsurance OON (Four visits)	$35 Copay IN; 40% Coinsurance OON (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		
PART D DRUGS					
Formulary	Performance		Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: 20%, Tier 4: 29%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 30%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 30%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 29%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 29%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 29%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 30%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 30%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 29%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 29%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 29%, Tier 5: 25%
OOP Threshold	$2,100. Once that is met, the plan pays the full cost for covered Part D drugs.		$2,100. 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. Excludes Deductible.	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		

Complete Blue PPO Distinct — WPA



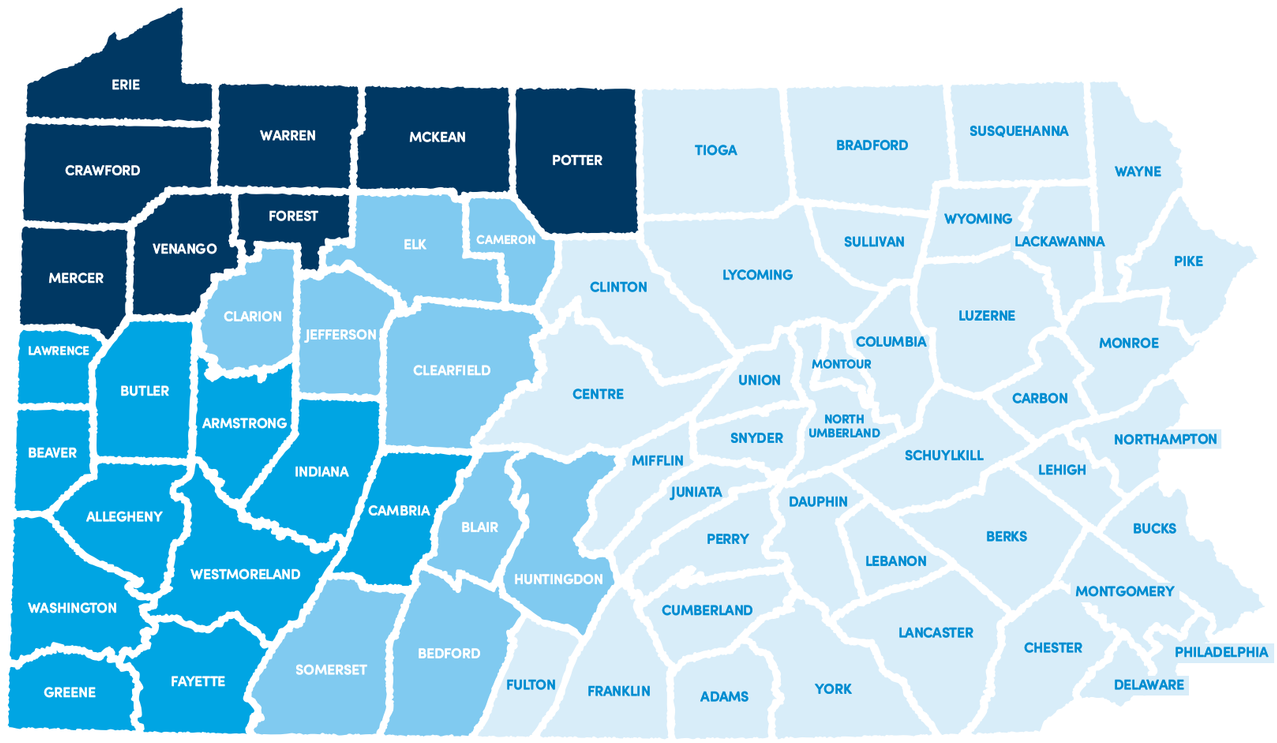
Region 1 **Region 2** **Region 3** **Region 4**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 2	REGION 3	REGION 4
Monthly Plan Premium	Region 1: $23; Region 2: $25	$30	$39
Part B Premium Giveback	Region 1: $0; Region 2: $6	$0	$0
Out-of-Pocket Maximum	$6,500 OOP Max; Combined: $9550 OOP Max	$6,500 OOP Max; Combined: $9,550 OOP Max	$6,500 OOP Max; Combined: $9,550 OOP Max
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		
Specialist Office Visit	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON		
X-rays	$20 Copay IN; 40% Coinsurance OON		
Radiation Therapy	$50 Copay IN; 40% Coinsurance OON		
Advanced Imaging	Region 1: $175 Copay IN; 40% Coinsurance OON; Region 2: $150 Copay IN; 40% Coinsurance OON	$175 Copay IN; 40% Coinsurance OON	$275 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	$10 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$10 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$10 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON		
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON		
Outpatient Surgical	ASC: Region 1: $175 Copay IN; $225 Copay OON; Region 2: $125 Copay IN; $250 Copay OON Facility: Region 1: $200 Copay IN; $250 Copay OON; Region 2: $150 Copay IN; $275 Copay OON	ASC: $175 Copay IN; $225 Copay OON Facility: $200 Copay IN; $250 Copay OON	ASC: $250 Copay IN; $300 Copay OON Facility: $300 Copay IN; $350 Copay OON
Ambulance	Region 1: Emergent/Non-Emergent: $260 Copay IN; Non-Emergent: 30% Coinsurance OON Region 2: Emergent/Non-Emergent: $200 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $460 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $465 Copay 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	$130 Copay		
Urgent Care	$40 Copay		
Inpatient Hospital Stay	$150/day (days 1 – 3), $0/day (days 4 – 90) IN; $275/day (days 1 – 3), $0/day (days 4 – 90) OON	$155/day (days 1 – 3), $0/day (days 4 – 90) IN; $275/day (days 1 – 3), $0/day (days 4 – 90) OON	$175/day (days 1 – 5), $0/day (days 6 – 90) 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; $475/day (days 1 – 3), $0/day (days 4 – 90) OON		
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON		
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		
Healing at Home	Not Covered		
OTC Catalog	Region 1: $95 Allowance Once Per Quarter; Region 2: $75 Allowance Once Per Quarter	$95 Allowance Once Per Quarter	$65 Allowance Once Per Quarter
Meal Benefit	Not Covered		
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
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		
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; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$10 Copay IN; $10 Copay OON (One every year)		
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $3,000	Combined maximum allowance of $3,000	Combined maximum allowance of $2,000
Comprehensive Dental — Supplemental	Region 1: 0% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative).; Region 2: 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.	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.	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; 40% Coinsurance OON		
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (four visits)		
Medicare Covered Podiatry	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Routine Podiatry	$25 Copay IN; 40% Coinsurance OON (four visits)	$25 Copay IN; 40% Coinsurance OON (four visits)	$30 Copay IN; 40% Coinsurance OON (four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: 20%, Tier 4: 30%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 30%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 30%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 30%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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 ValueRx — WPA



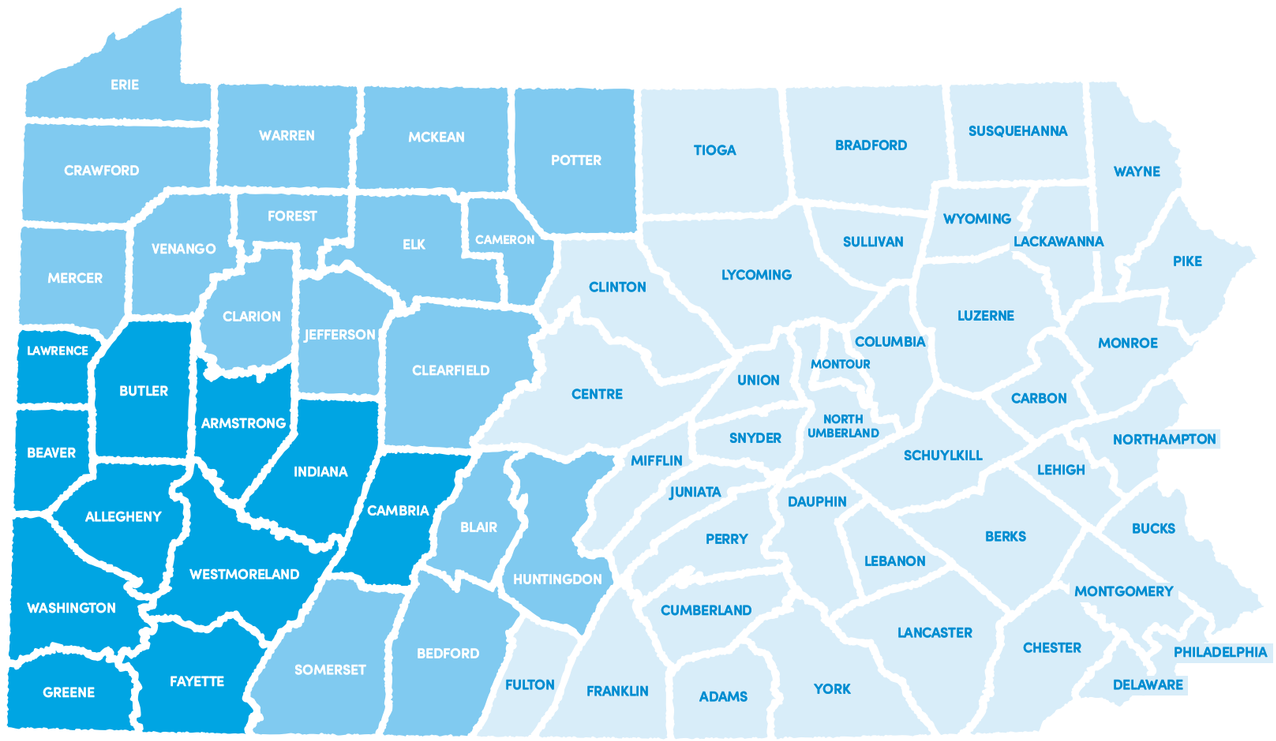
Region 1 **Region 2** **Region 3**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 3	REGION 2
Monthly Plan Premium	Region 1: $35; Region 3: $30	$36
Part B Premium Giveback	Region 1: $0 Region 3: $1	$1
Out-of-Pocket Maximum	$5,500 OOP Max; Combined: $8950 OOP Max	
PCP Office Visit	$0 Copay IN; $0 Copay POS	
Specialist Office Visit	$35 Copay IN; $40 Copay POS	
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; $25 Copay POS	
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$20 Copay IN; $25 Copay POS	$5 Copay IN; $25 Copay POS
X-rays	$20 Copay IN; $25 Copay POS	
Radiation Therapy	$60 Copay IN; $75 Copay POS	
Advanced Imaging	$175 Copay IN; $225 Copay POS	
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/POS	
Outpatient Physical and Speech Therapy	$40 Copay IN; $45 Copay POS	$10 Copay IN; $45 Copay POS
Medicare Covered Acupuncture	$40 Copay IN; $45 Copay POS	$10 Copay IN; $45 Copay POS
Outpatient Occupational Therapy	$40 Copay IN; $45 Copay POS	$10 Copay IN; $45 Copay POS
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; $45 Copay POS	
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; $45 Copay POS	
Outpatient Surgical	ASC: $175 Copay IN; $225 Copay POS Facility: $200 Copay IN; $250 Copay POS	
Ambulance	Region 1: $280 Copay IN; Region 3: $325 Copay IN	$340 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	$130 Copay	
Urgent Care	$50 Copay	
Inpatient Hospital Stay	$220/day (days 1 – 5), $0/day (days 6 – 90) IN; $270/day (days 1 – 5), $0/day (days 6 – 90) POS	
Inpatient Psychiatry Stay	$220/day (days 1 – 5), $0/day (days 6 – 90) IN; $270/day (days 1 – 5), $0/day (days 6 – 90) POS	
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	
Healing at Home	DME: Region 1: $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only; Region 2, 3: Not Covered Non-Skilled Care: Region 1: $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; Region 2, 3: Not Covered	
OTC Catalog	Not Covered	
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	
Fitness Benefit	Covered in Full IN	
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 POS	
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN	
Medicare Covered Vision (Office Visit)	$35 Copay IN; $40 Copay 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	$35 Copay IN; $40 Copay 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	
Routine Dental	Office Visit: $15 (for any combination of oral exam, X-ray, and prophylaxis provided in a single visit) IN (Two every year for exam and prophylaxis) X-ray: $15 Copay IN (One every year)	
Medicare Covered Comprehensive Dental	$35 Copay IN	
Dental Allowance — Preventive and/or Comprehensive	Not Covered	
Comprehensive Dental — Supplemental	$0 Copay: Adjunctive General Services (Palliative) IN	
Medicare Covered Chiropractic	$15 Copay IN; $40 Copay POS	
Routine Chiropractic	$15 Copay IN (Six visits)	
Medicare Covered Podiatry	$35 Copay IN; $40 Copay POS	
Routine Podiatry	$35 Copay IN (Eight visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay IN; 30% Coinsurance POS	
PART D DRUGS		
Formulary	Performance	
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: $13, Tier 3: $45, Tier 4: 35%, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: 35%, Tier 5: 33%	
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: 35%, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: 35%, Tier 5: 33%	
OOP Threshold	$2,100. 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. Excludes Deductible.	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



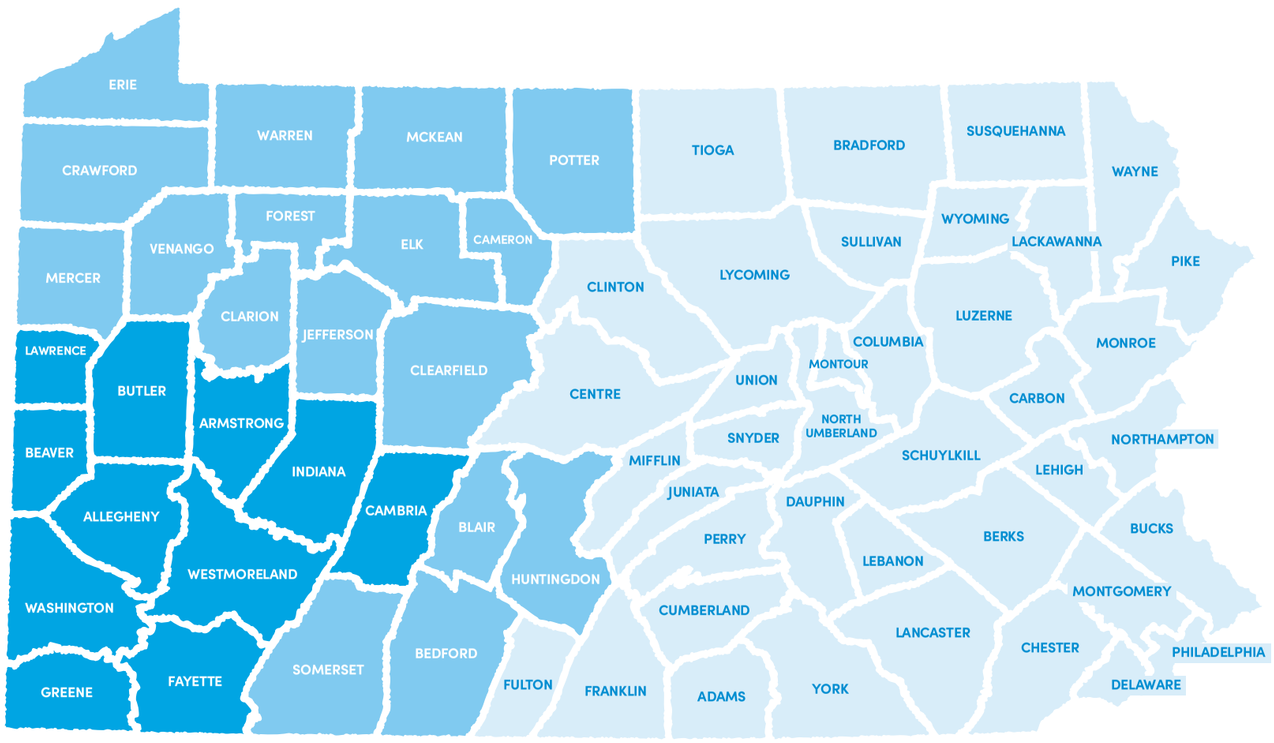
Region 1 **Region 2**

**Pricing is subject to CMS approval*

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

	SECURITY BLUE HMO-POS BASIC	SECURITY BLUE HMO-POS STANDARD	SECURITY BLUE HMO-POS DELUXE
Monthly Plan Premium	Region 1: $20; Region 2: $37	Region 1: $122; Region 2: $104	Region 1: $179; Region 2: $138
Part B Premium Giveback	Region 1: $23; Region 2: $0	$19	$19
Out-of-Pocket Maximum	Network: $5,900 OOP Max; Combined: $8,950 OOP Max	Network: $5,000 OOP Max; Combined: $8,950 OOP Max	Network: $4,500 OOP Max; Combined: $8,950 OOP Max
PCP Office Visit	$0 Copay IN; $0 Copay POS		
Specialist Office Visit	$30 Copay IN; $30 Copay POS	$30 Copay IN; $30 Copay POS	$25 Copay IN; $25 Copay POS
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; $30 Copay POS	$0 Copay IN; $15 Copay POS	$0 Copay IN; $15 Copay POS
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$20 Copay IN; $30 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; $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	$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 and Speech Therapy	$30 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Medicare Covered Acupuncture	$30 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Outpatient Occupational Therapy	$30 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS	$20 Copay IN; $30 Copay POS
Outpatient Mental Health and Psychiatric Therapy	$30 Copay IN; $45 Copay POS	$30 Copay IN; $35 Copay POS	$25 Copay IN; $30 Copay POS
Outpatient Substance Abuse and Opioid Treatment Services	$30 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: $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	Region 1: $270 Copay IN; Region 2: $280 Copay IN	Region 1: $270 Copay IN; Region 2: $290 Copay IN	Region 1: $260 Copay IN; Region 2: $265 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	$130 Copay		
Urgent Care	$50 Copay		
Inpatient Hospital Stay	$340/admit IN; $390/admit POS	$335/admit IN; $385/admit POS	$210/admit IN; $260/admit POS
Inpatient Psychiatry Stay	$340/admit IN; $390/admit POS	$335/admit IN; $385/admit POS	$210/admit IN; $260/admit POS
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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		
Healing at Home	Non-Skilled Care: Not Covered	DME: Region 1: $0 cost-share for DME up to a $1,000 allowance per calendar year upon Discharge from Inpatient Acute Hospital or SNF. IN Only; Region 2: Not Covered Non-Skilled Care: Region 1: $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; Region 2: Not Covered	
OTC Catalog	Not Covered		
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		
Fitness Benefit	Covered in Full IN		
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 POS		
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN		
Medicare Covered Vision (Office Visit)	$30 Copay IN; $30 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	$30 Copay IN; $30 POS	$25 Copay IN; $25 POS
Routine Hearing Exam	$0 Copay IN (One every year)		
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year IN; TruHearing Advanced — $599 copay; TruHearing Premium — $899 copay	2 Hearing Aids Every year IN; TruHearing Advanced — $599 copay; TruHearing Premium — $899 copay	2 Hearing Aids Every year IN; TruHearing Advanced — $399 copay; TruHearing Premium — $699 copay
Routine Dental	Office Visit: $15 (for any combination of oral exam, X-ray, and prophylaxis provided in a single visit) IN (Two every year for exam and prophylaxis) X-ray: $15 Copay IN (One every year)		
Medicare Covered Comprehensive Dental	$30 Copay IN	$30 Copay IN	$25 Copay IN
Dental Allowance — Preventive and/or Comprehensive	N/A		
Comprehensive Dental — Supplemental	$0 Copay: Adjunctive General Services (Palliative) IN		
Medicare Covered Chiropractic	$15 Copay IN; $30 Copay POS	$15 Copay IN; $30 Copay POS	$15 Copay IN; $25 Copay POS
Routine Chiropractic	$15 Copay IN (Six visits)	$15 Copay IN (Eight visits)	$15 Copay IN (10 visits)
Medicare Covered Podiatry	$30 Copay IN; $30 Copay POS	$30 Copay IN; $30 Copay POS	$25 Copay IN; $25 Copay POS
Routine Podiatry	$30 Copay IN (Eight visits)	$30 Copay IN (10 visits)	$25 Copay IN (12 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	$0 Copay IN; 30% Coinsurance POS		
PART D DRUGS			
Formulary	Not Covered	Venture	Venture
Deductible	Not Covered	$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.	Not Covered	Standard Retail: Tier 1: $0, Tier 2: $13, Tier 3: $44, Tier 4: $100, Tier 5: 33%	Standard Retail: Tier 1: $0, Tier 2: $13, Tier 3: $42, Tier 4: $100, Tier 5: 33%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Not Covered	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	Not Covered	$2,100. Once that is met, the plan pays the full cost for covered Part D drugs.	$2,100. 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. Excludes Deductible.	Not Covered	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

Freedom Blue PPO — WPA



Region 1 **Region 2**

**Pricing is subject to CMS approval*

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

	FREEDOM BLUE PPO VALUERx	FREEDOM BLUE PPO SELECT	FREEDOM BLUE PPO CLASSIC
Monthly Plan Premium	Region 1: $79; Region 2: $65	Region 1: $139; Region 2: $96	Region 1: $248; Region 2: $220
Part B Premium Giveback	$0		
Out-of-Pocket Maximum	$5,500 OOP Max; Combined: $8,950 OOP Max	$5,000 OOP Max; Combined: $8,950 OOP Max	$4500 OOP Max; Combined: $8,950 OOP Max
PCP Office Visit	$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 (Freestanding Lab)	$0 Copay IN; $20 Copay OON	$0 Copay IN; $15 Copay OON	$0 Copay IN; $10 Copay OON
Lab and Diagnostic Tests (Phys. Office or 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 and Speech Therapy	$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 Occupational Therapy	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; $40 Copay OON	$30 Copay IN; $30 Copay OON	$25 Copay IN; $25 Copay OON
Outpatient Substance Abuse and Opioid Treatment Services	$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: Region 1: $275 Copay IN; Region 2: Emergent/Non-Emergent: $320 Copay IN Non-Emergent: Region 1, 2: 30% Coinsurance OON	Emergent/Non-Emergent: Region 1: $300 Copay IN; Region 2: $350 Copay IN Non-Emergent: Region 1, 2: 30% Coinsurance OON	Emergent/Non-Emergent: Region 1: $255 Copay IN; Region 2: $325 Copay IN Non-Emergent: Region 1, 2: 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	$130 Copay		
Urgent Care	$50 Copay		
Inpatient Hospital 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
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); $218/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 Trividia, 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		
Healing at Home	Not Covered	DME: Region 1: $0 cost-share for DME up to a $1,000 allowance once per calendar year within 90 Days of Discharge from Inpatient Acute Hospital or SNF. IN/OON; Region 2: Not Covered Non-Skilled Care: Region 1: $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; Region 2: Not Covered	
OTC Catalog	Not Covered		
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		
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
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		
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 or 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)	Two 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 (for any combination of oral exam, X-ray, and prophylaxis provided in a single visit) IN (Two every year for exam and prophylaxis); 30% Coinsurance OON 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
Dental Allowance — Preventive and/or Comprehensive	Not Covered		
Comprehensive Dental — Supplemental	$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON		
Medicare Covered Chiropractic	$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/ Intensive Outpatient Program Services, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	Performance	Venture	Venture
Deductible	$0	$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: $13, Tier 3: $45, Tier 4: 35%, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: 35%, Tier 5: 33%	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: 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%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: 35%, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: 35%, Tier 5: 33%	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, Tier 5: 33%	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, Tier 5: 33%
OOP Threshold	$2,100. 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. Excludes Deductible.	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

Strong medical benefits and low out-of-pocket costs with coordinated care centered around AHN hospitals and doctors.

- $38 monthly Part B Giveback
- $0 Copay PCP and X-rays
- Inpatient Hospital PER STAY Copay
- $3,000 Dental allowance with no coinsurance
- $0 Tier 1 and 2 Drugs with no deductible

Community Blue Medicare HMO Signature

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

- $0 Copay PCP
- Inpatient Hospital PER STAY Copay in most regions
- $3,000 Dental allowance with no coinsurance
- $0 Tier 1 and 2 Drugs with no deductible

NEW PLAN

Complete Blue HMO Distinct

Premium MA plan with rich medical and robust supplemental benefits including a generous dental allowance and a broad network of providers including AHN, UPMC, and most local hospitals in WPA.

- $0 Copay PCP
- $0 Copay Routine Dental office visit and X-Ray
- Inpatient Hospital PER STAY Copay in most regions
- OTC up to $90 allowance per quarter
- $3,000 Dental allowance with no coinsurance
- $0 Tier 1 and 2 Drugs with no deductible

Complete Blue PPO Merit

$0 MA plan with over $1,000 in annual Part B Givebacks for the most cost-conscious consumer or low utilizers that still want access to high quality care.

- $90 monthly Part B Giveback
- $0 Copay PCP IN
- $1,500 Dental allowance
- $0 Tier 1 and 2 Drugs with no deductible

Complete Blue PPO Signature

Fundamental $0 MA plan that provides in-network access to AHN, UPMC, and most local hospitals in WPA as well as national provider access through the BlueCard® Program.

- $0 Copay PCP IN; $0 – $10 Copay Lab IN
- $0 Copay Routine Dental office visits and X-Ray IN
- Up to $2,500 Dental allowance
- $0 Tier 1 Drugs with no deductible

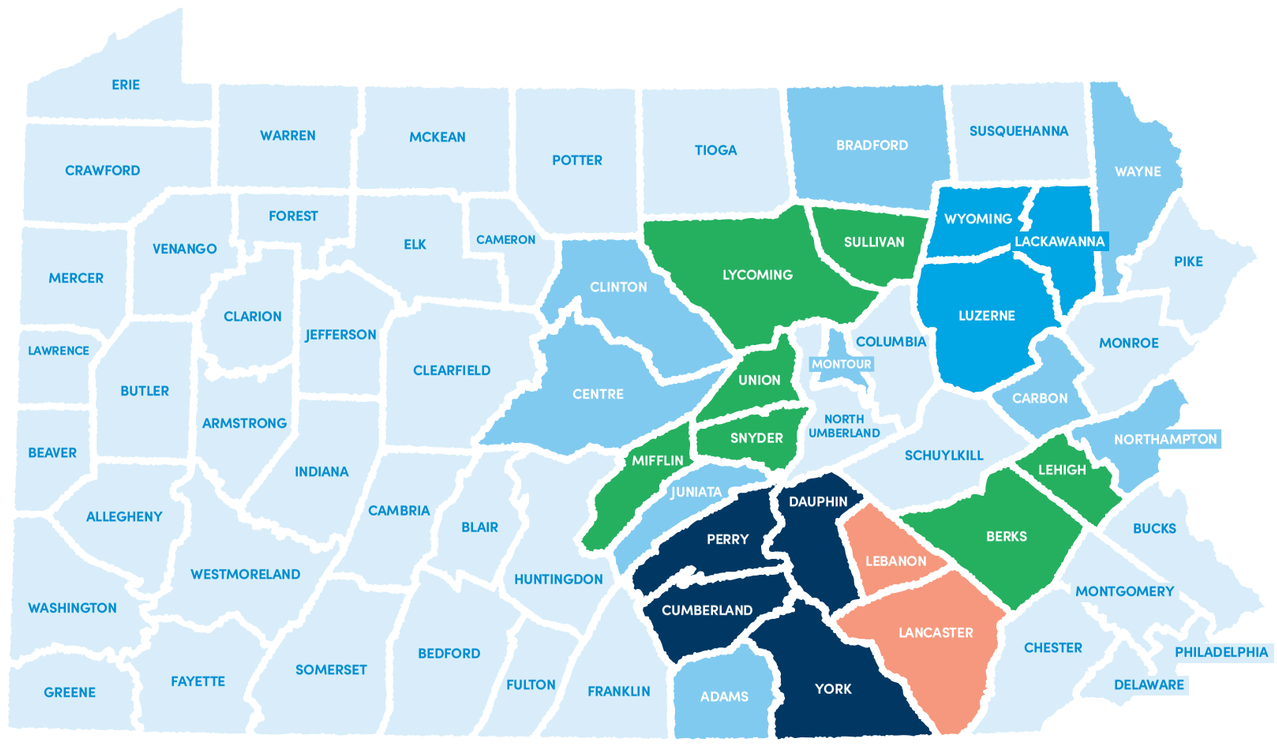
Complete Blue PPO Distinct

Premium plan with core medical and supplemental benefits in addition to an extensive local network.

- $0 Copay PCP IN; $0 – $10 Copay Lab IN
- $25 – $30 Copay Specialist IN
- Up to $3,000 Dental allowance; 10% coinsurance or less in most regions IN
- $0 Tier 1 Drugs with no deductible

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

Community Blue Medicare HMO Signature — CPA/NEPA



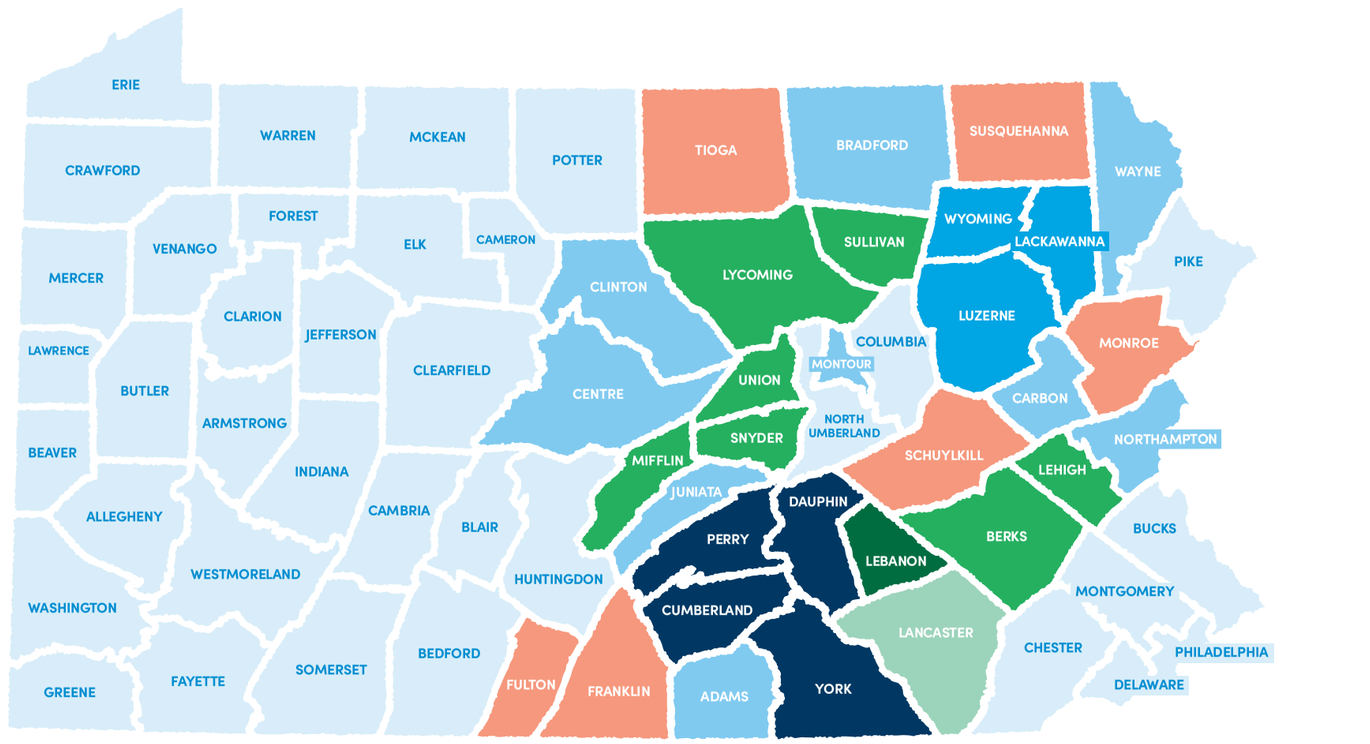
Region 1 **Region 2** **Region 3** **Region 4** **Region 5**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 2/ REGION 3 / REGION 4 / REGION 5
Monthly Plan Premium	$0
Part B Premium Giveback	Region 1: $27; Region 2: $0; Region 3, 4: $22; Region 5: $16
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: N/A
PCP Office Visit	$0 Copay
Specialist Office Visit	$20 Copay
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay
X-rays	$10 Copay
Radiation Therapy	$60 Copay
Advanced Imaging	Region 1, 2, 5: $200 Copay; Region 3, 4: $150 Copay
Preventive/Screening	Covered in Full (Office visit copay may apply)
Outpatient Physical and Speech Therapy	$20 Copay
Medicare Covered Acupuncture	$20 Copay
Outpatient Occupational Therapy	$20 Copay
Outpatient Mental Health and Psychiatric Therapy	$30 Copay
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay
Outpatient Surgical	ASC: Region 1, 2, 5: $200 Copay; Region 3, 4: $150 Copay Facility: Region 1, 2, 5: $250 Copay; Region 3, 4: $200 Copay
Ambulance	Region 1: $275 Copay; Region 2, 5: $250 Copay; Region 3, 4: $175 Copay
Transportation	$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	$130 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	$325/admit
Inpatient Psychiatry Stay	$425/day (days 1 – 3), $0/day (days 4 – 90)
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.
Healing at Home	Not Covered
OTC Catalog	$40 Allowance Once Per Quarter
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full
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
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)	$20 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 $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	$20 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay (One every year)
Medicare Covered Comprehensive Dental	$20 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	$20 Copay
Routine Podiatry	$20 Copay (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Distinct — CPA/NEPA



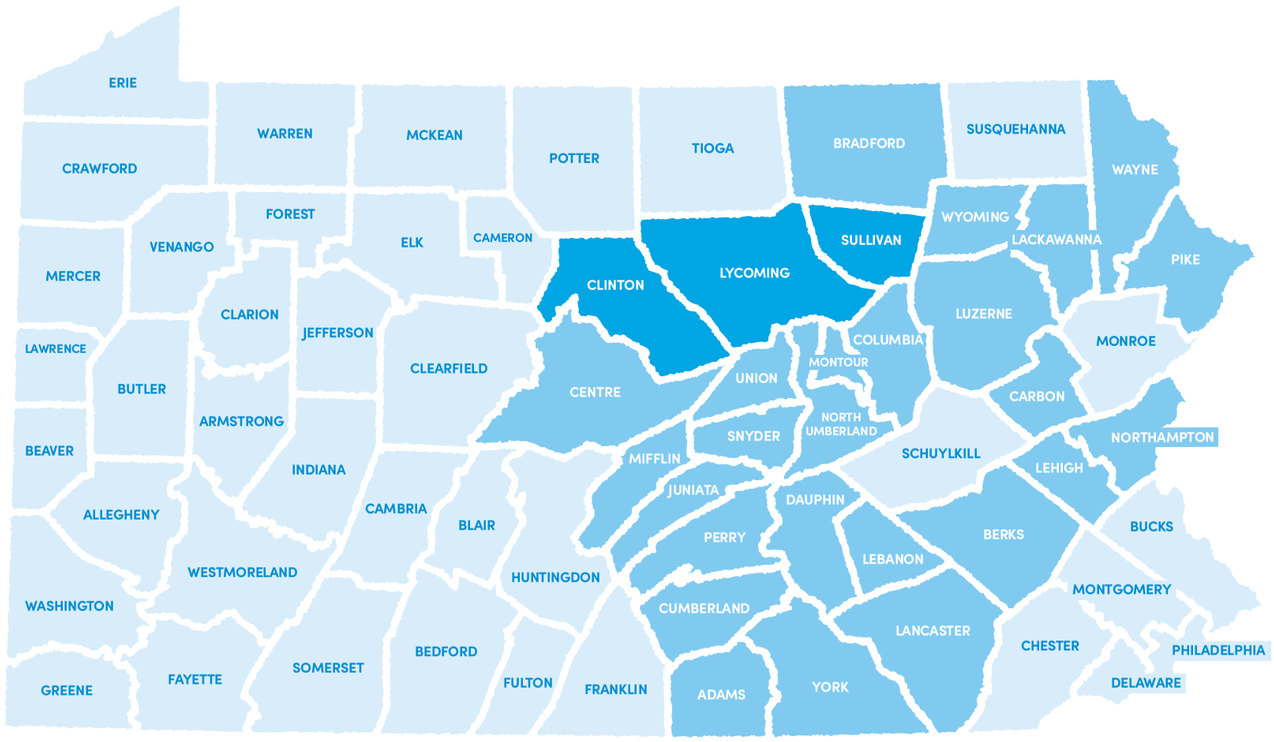
Region 1 **Region 2** **Region 3** **Region 4** **Region 5** **Region 6** **Region 7**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 6 / REGION 7	REGION 2	REGION 3	REGION 4 / REGION 5
Monthly Plan Premium	$27	$27	$35	Region 4: $50; Region 5: $55
Part B Premium Giveback	$0			
Out-of-Pocket Maximum	Network: $6,250 OOP Max; Combined: N/A			
PCP Office Visit	$0 Copay			
Specialist Office Visit	$20 Copay	$25 Copay	$30 Copay	$35 Copay
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay			
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay			
X-rays	$10 Copay			
Radiation Therapy	$60 Copay			
Advanced Imaging	$200 Copay	$250 Copay	$250 Copay	$250 Copay
Preventive/Screening	Covered in Full (Office visit copay may apply)			
Outpatient Physical and Speech Therapy	$20 Copay	$20 Copay	$20 Copay	$25 Copay
Medicare Covered Acupuncture	$20 Copay	$20 Copay	$20 Copay	$25 Copay
Outpatient Occupational Therapy	$20 Copay	$20 Copay	$20 Copay	$25 Copay
Outpatient Mental Health and Psychiatric Therapy	$30 Copay			
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay			
Outpatient Surgical	ASC: $195 Copay; Facility: $245 Copay	ASC: $195 Copay; Facility: $245 Copay	ASC: $225 Copay; Facility: $275 Copay	ASC: $250 Copay; Facility: $300 Copay
Ambulance	$345 Copay			
Transportation	$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.			
Emergency Room	$130 Copay			
Urgent Care	$40 Copay			
Inpatient Hospital Stay	$295/admit	$325/admit	$350/admit	$400/admit
Inpatient Psychiatry Stay	$425/day (days 1 – 3), $0/day (days 4 – 90)			
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.			
Healing at Home	Not Covered			
OTC Catalog	$75 Allowance Once Per Quarter	$75 Allowance Once Per Quarter	$75 Allowance Once Per Quarter	Region 4: $75 Allowance Once Per Quarter; Region 5: $40 Allowance Once Per Quarter
Meal Benefit	Not Covered			
Fitness Benefit	Covered in Full			
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			
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)	$20 Copay	$25 Copay	$30 Copay	$35 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 $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	$20 Copay	$25 Copay	$30 Copay	$35 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	$0 Copay (Two every year) Includes exam, cleaning, and fluoride treatment			
	$0 Copay (One every year)			
Medicare Covered Comprehensive Dental	$20 Copay	$25 Copay	$30 Copay	$35 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	$20 Copay	$25 Copay	$30 Copay	$35 Copay
Routine Podiatry	$20 Copay (Four visits)	$25 Copay (Four visits)	$30 Copay (Four visits)	$35 Copay (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay			
PART D DRUGS				
Formulary	Performance			
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615			
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: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%			
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%			
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy			

Complete Blue Plus PPO Merit and Complete Blue PPO Merit — CPA/NEPA



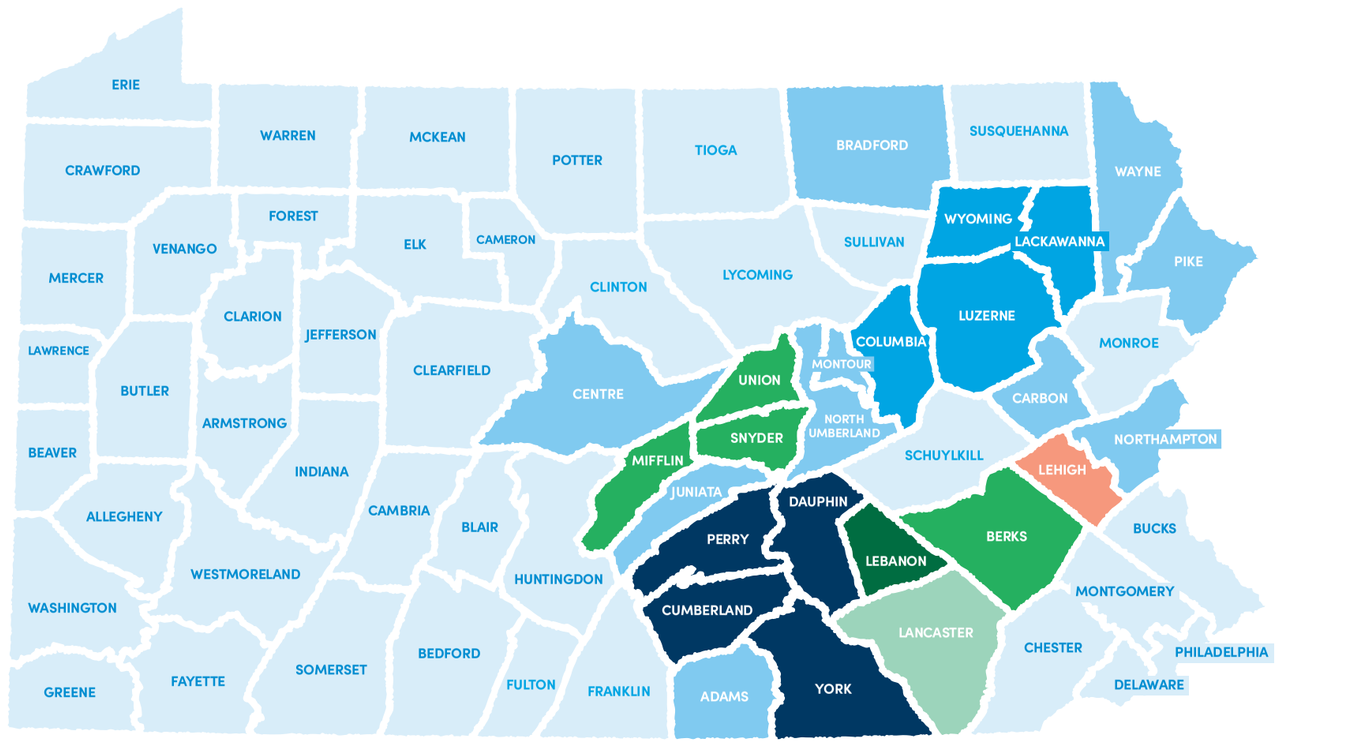
Complete Blue Plus PPO Merit **Complete Blue PPO Merit**

**Pricing is subject to CMS approval*

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

	COMPLETE BLUE PLUS PPO MERIT	COMPLETE BLUE PPO MERIT
Monthly Plan Premium	$0	
Part B Premium Giveback	$91	
Out-of-Pocket Maximum	Network: $8,300 OOP Max; Combined: $8,950 OOP Max	
	$200	
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON +	
Specialist Office Visit	$40 Copay IN; 40% Coinsurance OON +	
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay (Lab) IN; $0 Copay (Diagnostic) IN +; 40% Coinsurance OON +	
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay (Lab) IN; $10 Copay (Diagnostic) IN +; 40% Coinsurance OON +	
X-rays	$20 Copay IN +; 40% Coinsurance OON +(Deductible does not apply to diagnostic mammograms IN)	
Radiation Therapy	$60 Copay IN +; 40% Coinsurance OON +	
Advanced Imaging	$300 Copay IN +; 40% Coinsurance OON +	
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	$35 Copay IN +; 40% Coinsurance OON +	
Medicare Covered Acupuncture	$35 Copay IN +; 40% Coinsurance OON +	
Outpatient Occupational Therapy	$35 Copay IN +; 40% Coinsurance OON +	
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN +; 40% Coinsurance OON +	
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN +; 40% Coinsurance OON +	
Outpatient Surgical	ASC: $325 Copay IN +; $ 475 Copay OON + (Deductible does not apply to diagnostic colonoscopy IN) Facility: $375 Copay IN +; $475 Copay OON + (Deductible does not apply to diagnostic colonoscopy IN)	
Ambulance	Emergent/Non-Emergent: $320 Copay 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	$115 Copay	
Urgent Care	$40 Copay	
Inpatient Hospital Stay	$400/day (days 1 – 5) IN, $0/day (days 6 – 90) IN +; $600/day (days 1 – 5), $0/day (days 6 – 90) OON +	
Inpatient Psychiatry Stay	$400/day (days 1 – 5), $0/day (days 6 – 90) IN +; $475/day (days 1 – 5), $0/day (days 6 – 90) OON +	
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON +	
Durable Medical Equipment	20% Coinsurance IN +; 40% Coinsurance OON +	
Healing at Home	Not Covered	
OTC Catalog	Not Covered	
Meal Benefit	Not Covered	
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON	
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+	
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% Coinsurance 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.	
Medicare Covered Hearing Exam	$40 Copay IN; 40% Coinsurance OON+	
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One every year)	
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)	
Medicare Covered Comprehensive Dental	$40 Copay IN; 40% Coinsurance OON+	
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500	
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 +; 40% Coinsurance OON +	
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Four visits)	
Medicare Covered Podiatry	$40 Copay IN; 40% Coinsurance OON +	
Routine Podiatry	$40 Copay IN; 40% Coinsurance OON (Four visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN +; 40% Coinsurance OON + Outpatient Blood: $0 Copay IN +; 30% Coinsurance OON +	
PART D DRUGS		
Formulary	Performance	
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615	
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: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	
OOP Threshold	$2,100. 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. Excludes Deductible.	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



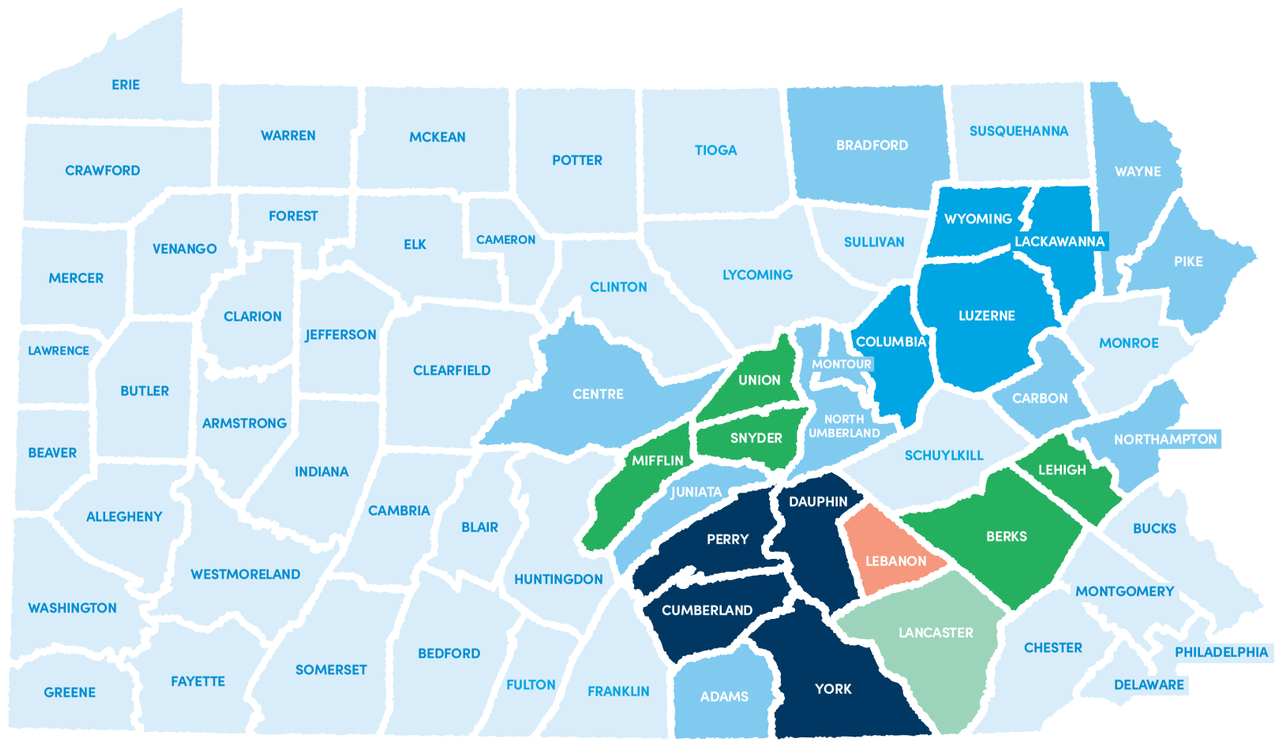
Region 1 **Region 2** **Region 3** **Region 4** **Region 5** **Region 6** **Region 7**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 2	REGION 3 / REGION 5 / REGION 6 / REGION 7	REGION 4
Monthly Plan Premium	$0		
Part B Premium Giveback	Region 1: $13; Region 2: $11	Region 3, 7: $12; Region 5: $24; Region 6: $28	$0
Out-of-Pocket Maximum	Network: $7,950 OOP Max; Combined: $10,000 OOP Max		
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		
Specialist Office Visit	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON		
X-rays	$20 Copay IN; 40% Coinsurance OON		
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON		
Advanced Imaging	$195 Copay IN; 40% Coinsurance OON	$195 Copay IN; 40% Coinsurance OON	$350 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON		
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON		
Outpatient Surgical	ASC: $275 Copay IN; $400 Copay OON Facility: $350 Copay IN; $425 Copay OON	ASC: Region 3, 5, 7: $300 Copay IN; $400 Copay OON; Region 6: $275 Copay IN; $400 Copay OON Facility: Region 3, 5, 6, 7: $350 Copay IN; $425 Copay OON	ASC: $400 Copay IN; $475 Copay OON Facility: $450 Copay IN; $525 Copay OON
Ambulance	Emergent/Non-Emergent: Region 1: $275 Copay IN; Region 2: $260 Copay IN Non-Emergent: Region 1: 30% Coinsurance OON; Region 2: 30% Coinsurance OON	Emergent/Non-Emergent: Region 3, 5, 6: $260 Copay IN; Region 7: $315 Copay IN Non-Emergent: Region 3, 5, 6, 7: 30% Coinsurance OON	Emergent/Non-Emergent: $405 Copay 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	$115 Copay		
Urgent Care	$40 Copay		
Inpatient Hospital Stay	Region 1: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $225/day (days 1 – 5), $0/day (days 6 – 90) OON; Region 2: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 5), $0/day (days 6 – 90) OON	Region 3, 5: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 7), $0/day (days 8 – 90) OON Region 6, 7: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $275/day (days 1 – 5), $0/day (days 6 – 90) OON	$270/day (days 1 – 10), $0/day (days 11 – 90) IN; $350/day (days 1 – 10), $0/day (days 11 – 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		
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON		
Durable Medical Equipment	20% Coinsurance IN; 40% Coinsurance OON		
Healing at Home	Not Covered		
OTC Catalog	Region 1: $40 Allowance Once Per Quarter; Region 2: $50 Allowance Once Per Quarter	Region 3, 5: $40 Allowance Once Per Quarter; Region 6, 7: $50 Allowance Once Per Quarter	$30 Allowance Once Per Quarter
Meal Benefit	Not Covered		
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
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		
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; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance 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 or a $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$25 Copay IN; $25 Copay OON (One every year)	Region 3, 5: $20 Copay IN; $20 Copay OON (One every year); Region 6, 7: $25 Copay IN; $25 Copay OON (One every year)	$25 Copay IN; $25 Copay OON (One every year)
Routine Hearing (Hearing Aids)	3 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500	Combined maximum allowance of $2,500	Combined maximum allowance of $2,000
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.	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.	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; 40% Coinsurance OON		
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Four visits)		
Medicare Covered Podiatry	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON
Routine Podiatry	$35 Copay IN; 40% Coinsurance OON (Four visits)	$35 Copay IN; 40% Coinsurance OON (Four visits)	$50 Copay IN; 40% Coinsurance OON (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy		

Complete Blue PPO Distinct — CPA/NEPA



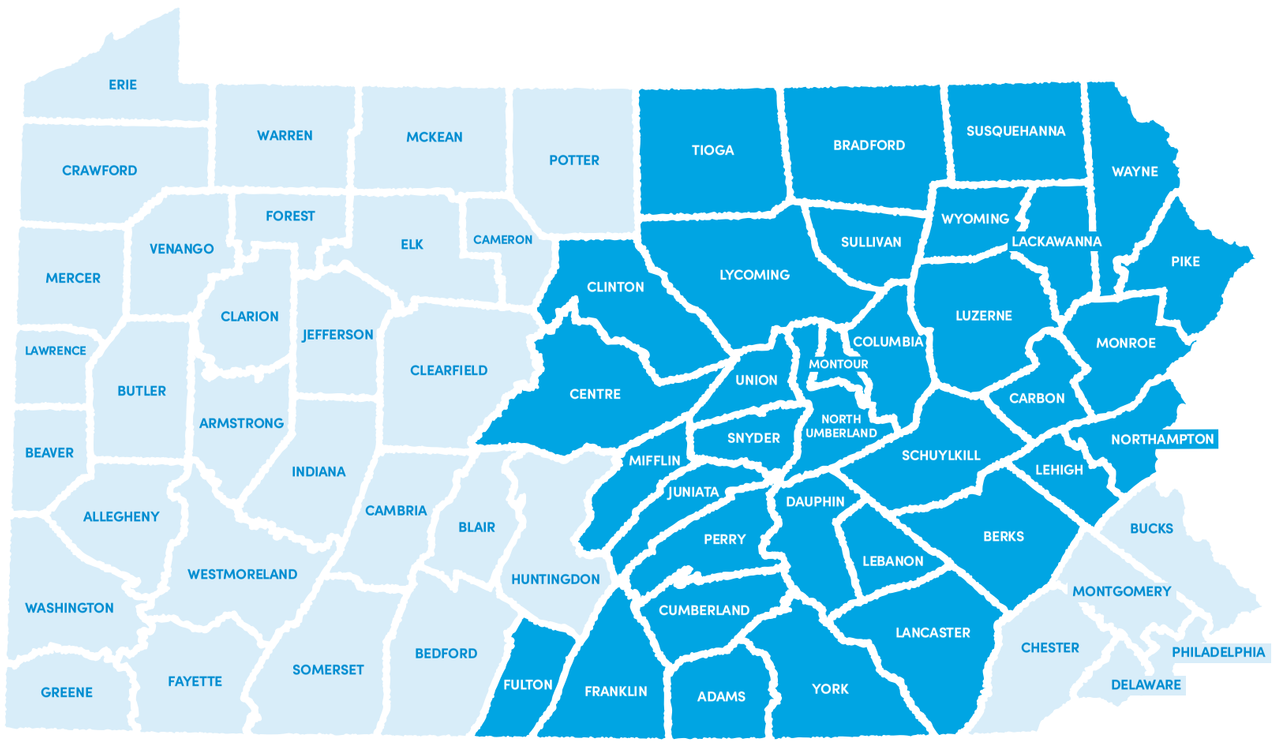
Region 1 **Region 2** **Region 3** **Region 4** **Region 5** **Region 6**

**Pricing is subject to CMS approval*

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

	REGION 1 / REGION 2 / REGION 5 / REGION 6	REGION 3	REGION 4
Monthly Plan Premium	Region 1, 5, 6: $55; Region 2: $58	$72	$98
Part B Premium Giveback	$0		
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: $8,950 OOP Max		
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		
Specialist Office Visit	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON		
X-rays	Region 1, 2, 6: $20 Copay IN; 40% Coinsurance OON; Region 5: $15 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON		
Advanced Imaging	$225 Copay IN; 40% Coinsurance OON	$195 Copay IN; 40% Coinsurance OON	$300 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$30 Copay IN; 40% Coinsurance OON		
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON		
Outpatient Surgical	ASC: Region 1, 2, 5, 6: $225 Copay IN; $275 Copay OON Facility: Region 1: $275 Copay IN; $350 Copay OON; Region 2, 5, 6: $275 Copay IN; $325 Copay OON	ASC: $250 Copay IN; $300 Copay OON Facility: $300 Copay IN; $350 Copay OON	ASC: $300 Copay IN; $350 Copay OON Facility: $350 Copay IN; $400 Copay OON
Ambulance	Emergent/Non-Emergent: Region 1: $400 Copay IN; Region 2, 5:$370 Copay IN; Region 6: $305 Copay IN; Non-Emergent: Region 1, 2, 5, 6: 30% Coinsurance OON	Emergent/Non-Emergent: $400 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $380 Copay 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	$130 Copay		
Urgent Care	$40 Copay		
Inpatient Hospital Stay	Region 1: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $225/day (days 1 – 5), $0/day (days 6 – 90) OON; Region 2, 5, 6: $175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 5), $0/day (days 6 – 90) OON	$175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 5), $0/day (days 6 – 90) OON	$250/day (days 1 – 7), $0/day (days 8 – 90) IN; $300/day (days 1 – 7), $0/day (days 8 – 90) OON
Inpatient Psychiatry Stay	$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $425/day (days 1 – 3), $0/day (days 4 – 90) OON		
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON		
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		
Healing at Home	Not Covered		
OTC Catalog	$55 Allowance Once Per Quarter	$50 Allowance Once Per Quarter	Not Covered
Meal Benefit	Not Covered		
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
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		
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; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		
Medicare Covered Hearing Exam	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	Region 1, 2, 6: $15 Copay IN; $15 Copay OON (One every year); Region 5: $5 Copay IN; $5 Copay OON (One every year)	$15 Copay IN; $15 Copay OON (One every year)	$15 Copay IN; $15 Copay OON (One every year)
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		
Medicare Covered Comprehensive Dental	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Region 1, 5, 6: Combined maximum allowance of $2,500; Region 2: Combined maximum allowance of $2,000	Combined maximum allowance of $2,000	Combined maximum allowance of $1,500
Comprehensive Dental — Supplemental	25% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative. 25% All others). 50% Coinsurance OON. See EOC for benefit limits.	25% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative. 25% All others). 50% Coinsurance OON. See EOC for benefit limits.	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; 40% Coinsurance OON		
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Four visits)		
Medicare Covered Podiatry	$30 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Podiatry	$30 Copay IN; 40% Coinsurance OON (Four visits)	$40 Copay IN; 40% Coinsurance OON (Four visits)	$40 Copay IN; 40% Coinsurance OON (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		
OOP Threshold	$2,100. 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. Excludes Deductible.	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 — CPA/NEPA



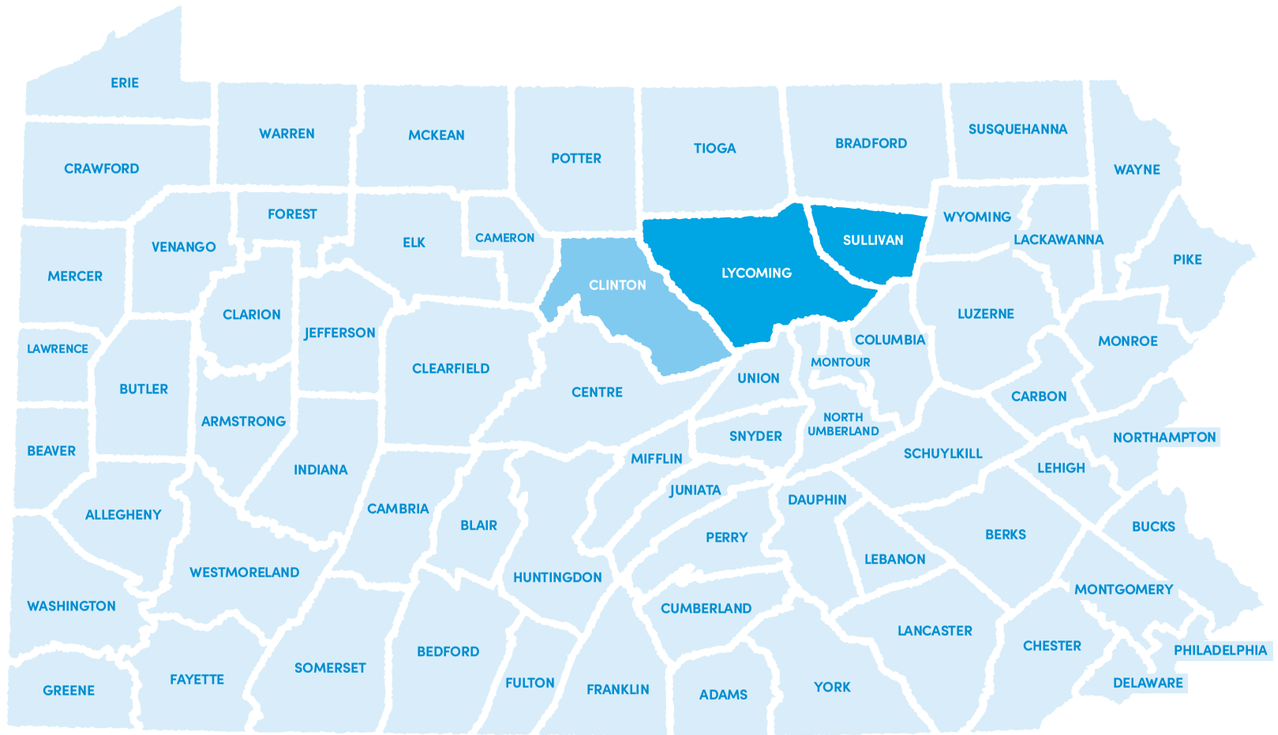
Freedom Blue PPO

**Pricing is subject to CMS approval*

Freedom Blue PPO — CPA/NEPA (Products and pricing by county)

	FREEDOM BLUE PPO VALUERx	FREEDOM BLUE PPO BASIC	FREEDOM BLUE PPO STANDARD	FREEDOM BLUE PPO DELUXE
Monthly Plan Premium	$66	$41	$121	$226
Part B Premium Giveback	$0	$18		$19
Out-of-Pocket Maximum	Network: $5,500 OOP Max; Combined: $8,950 OOP Max	Network: $5,900 OOP Max; Combined: $8,950 OOP Max	Network: $5,000 OOP Max; Combined: $8,950 OOP Max	Network: $4,500 OOP Max; Combined: $8,950 OOP Max
PCP Office Visit	$0 Copay IN; $0 Copay OON			
Specialist Office Visit	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON		$30 Copay IN; $30 Copay OON
Lab and Diagnostic Tests (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 (Phys. Office or 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	$175 Copay IN; $175 Copay OON	$150 Copay IN; $150 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 and Speech Therapy	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Medicare Covered Acupuncture	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Outpatient Occupational Therapy	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Outpatient Surgical	ASC: $200 Copay IN; $200 Copay OON Facility: $225 Copay IN; $225 Copay OON	ASC: $100 Copay IN; $100 Copay OON Facility: $200 Copay IN; $200 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: $270 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $270 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $260 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $275 Copay 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	$130 Copay			
Urgent Care	$50 Copay			
Inpatient Hospital Stay	$245/day (days 1 – 5), $0/day (days 6 – 90) IN; $245/day (days 1 – 5), $0/day (days 6 – 90) OON	$340/admit IN; $340/admit OON	$475/admit IN; $475/admit OON	$235/admit IN; $235/admit OON
Inpatient Psychiatry Stay	$245/day (days 1 – 5), $0/day (days 6 – 90) IN; $245/day (days 1 – 5), $0/day (days 6 – 90) OON	$340/admit IN; $340/admit OON	$475/admit IN; $475/admit OON	$235/admit IN; $235/admit OON
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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			
Healing at Home	Not Covered			
OTC Catalog	Not Covered			
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			
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON			
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			
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	$35 Copay IN; $35 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 or 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	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Routine Hearing Exam	$0 Copay IN; $40 Copay OON (One every year)	$0 Copay IN; $35 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 — $599 copay; TruHearing Premium — $899 copay IN; $500 allowance IN/OON for any other hearing aid	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 (for any combination of oral exam, X-ray, and prophylaxis provided in a single visit) IN (Two every year); 30% Coinsurance OON X-ray: $15 Copay IN; 30% Coinsurance OON (One every year)			
Medicare Covered Comprehensive Dental	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Dental Allowance — Preventive and/or Comprehensive	N/A			
Comprehensive Dental — Supplemental	$0 Copay: Adjunctive General Services (Palliative) IN; 30% OON			
Medicare Covered Chiropractic	$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 (Eight visits)	$15 Copay IN; $15 Copay OON (10 visits)
Medicare Covered Podiatry	$40 Copay IN; $40 Copay OON	$35 Copay IN; $35 Copay OON	$35 Copay IN; $35 Copay OON	$30 Copay IN; $30 Copay OON
Routine Podiatry	$40 Copay IN; $40 Copay OON (Eight visits)	$35 Copay IN; $35 Copay OON (10 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/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	Performance	Not Covered	Venture	Venture
Deductible	$0	Not Covered	$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: $13, Tier 3: $45, Tier 4: 30%, Tier 5: 33% Standard Retail: Tier 1: $5, Tier 2: $19, Tier 3: $47, Tier 4: 30%, Tier 5: 33%	Not Covered	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: 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%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: 30%, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: 30%, Tier 5: 33%	Not Covered	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, Tier 5: 33%	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, Tier 5: 33%
OOP Threshold	$2,100. Once that is met, the plan pays the full cost for covered Part D drugs.	Not Covered	$2,100. Once that is met, the plan pays the full cost for covered Part D drugs.	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy	Not Covered	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

Community Blue Medicare Plus PPO Signature and Complete Blue Plus PPO Distinct — CPA/NEPA



Region 1 **Region 2**

**Pricing is subject to CMS approval*

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

	COMMUNITY BLUE MEDICARE PLUS PPO SIGNATURE		COMPLETE BLUE PLUS PPO DISTINCT	
	REGION 1	REGION 2	REGION 1	REGION 2
Monthly Plan Premium	$0		$72	$99
Part B Premium Giveback	$17	$0	$0	$0
Out-of-Pocket Maximum	Network: $7,950 OOP Max; Combined: $10,000 OOP Max		Network: $6,750 OOP Max; Combined: $8,950 OOP Max	
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON			
Specialist Office Visit	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON			
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON			
X-rays	$20 Copay IN; 40% Coinsurance OON			
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON			
Advanced Imaging	$195 Copay IN; 40% Coinsurance OON	$350 Copay IN; 40% Coinsurance OON	$195 Copay IN; 40% Coinsurance OON	$300 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON			
Outpatient Physical and Speech Therapy	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON			
Outpatient Surgical	ASC: $300 Copay IN; $400 Copay OON Facility: $350 Copay IN; $425 Copay OON	ASC: $400 Copay IN; $475 Copay OON Facility: $450 Copay IN; $525 Copay OON	ASC: $250 Copay IN; $300 Copay OON Facility: $300 Copay IN; $350 Copay OON	ASC: $300 Copay IN; $350 Copay OON Facility: $350 Copay IN; $400 Copay OON
Ambulance	Emergent/Non-Emergent: $260 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $315 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $370 Copay IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $375 Copay 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	$115 Copay	$115 Copay	$130 Copay	$130 Copay
Urgent Care	$40 Copay			
Inpatient Hospital Stay	$175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 5), $0/day (days 6 – 90) OON	$270/day (days 1 – 10), $0/day (days 11 – 90) IN; $350/day (days 1 – 10), $0/day (days 11 – 90) OON	$175/day (days 1 – 5), $0/day (days 6 – 90) IN; $250/day (days 1 – 5), $0/day (days 6 – 90) OON	$250/day (days 1 – 7), $0/day (days 8 – 90) IN; $300/day (days 1 – 7), $0/day (days 8 – 90) OON
Inpatient Psychiatry Stay	$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $500/day (days 1 – 3), $0/day (days 4 – 90) OON		$425/day (days 1 – 3), $0/day (days 4 – 90) IN; $425/day (days 1 – 3), $0/day (days 4 – 90) OON	
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON			
Durable Medical Equipment	20% Coinsurance IN; 40% Coinsurance OON		0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories; 0% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON	
Healing at Home	Not Covered			
OTC Catalog	$100 Allowance Once Per Quarter	$30 Allowance Once Per Quarter	$50 Allowance Once Per Quarter	Not Covered
Meal Benefit	Not Covered			
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON			
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			
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; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance 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 or 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.	
Medicare Covered Hearing Exam	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$20 Copay IN; $20 Copay OON (One every year)	$25 Copay IN; $25 Copay OON (One every year)	$15 Copay IN; $15 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 TruHearing models not Advanced or Premium			
Routine Dental	Office Visit: $0 Copay IN; 30% Coinsurance OON (Two every year) Includes exam, cleaning, and fluoride treatment; X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)			
Medicare Covered Comprehensive Dental	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500		Combined maximum allowance of $2,000	Combined maximum allowance of $1,500
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.	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.	25% Coinsurance: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative. 25% All others). 50% Coinsurance OON. See EOC for benefit limits.	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; 40% Coinsurance OON			
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Four visits)			
Medicare Covered Podiatry	$35 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Podiatry	$35 Copay IN; 40% Coinsurance OON (Four visits)	$50 Copay IN; 40% Coinsurance OON (Four visits)	$40 Copay IN; 40% Coinsurance OON (Four visits)	$40 Copay IN; 40% Coinsurance OON (Four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON; Outpatient Blood: $0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	Performance			
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615			
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: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 23%,Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%		Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%	
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy			

CPA/NEPA Growth Product Highlights

Community Blue Medicare HMO Signature

$0 MA plan with strong core medical and supplemental benefits in exchange for a narrower network.

- $0 Copay PCP
- $10 Copay X-Rays
- $20 Copay Physical Therapy
- Inpatient Hospital PER STAY Copay
- $3,000 dental allowance with no coinsurance

NEW PLAN

Community Blue Medicare HMO Distinct

Premium MA plan with rich medical and more robust supplemental benefits offering predictability in exchange for a narrower network.

- $0 Copay PCP
- $10 Copay X-Rays
- Inpatient Hospital PER STAY Copay
- $75 OTC Allowance once per quarter in most regions
- $3,000 dental allowance with no coinsurance
- $0 Tier 1 and 2 Drugs with no deductible

NEW PLANS

Complete Blue Plus PPO Merit

Complete Blue PPO Merit

$0 MA plan with over $1,000 in annual Part B Givebacks for the most cost-conscious consumer or low utilizers that still want access to high-quality care.

- $91 Part B Premium Giveback
- $0 Copay PCP IN
- $0 Copay Routine Dental office visits and X-Ray IN
- $1,500 Dental Allowance
- $0 Tier 1 and 2 Drugs with no deductible

Community Blue Medicare PPO Signature

Fundamental $0 MA plan with strong core medical benefits, no deductible, a broader local network, and national access through the BlueCard® Program.

- $0 Copay PCP IN
- $0 Copay Routine Dental office visits and X-Ray IN
- Up to $2,500 dental allowance
- $0 Tier 1 Drugs with no deductible

Complete Blue PPO Distinct

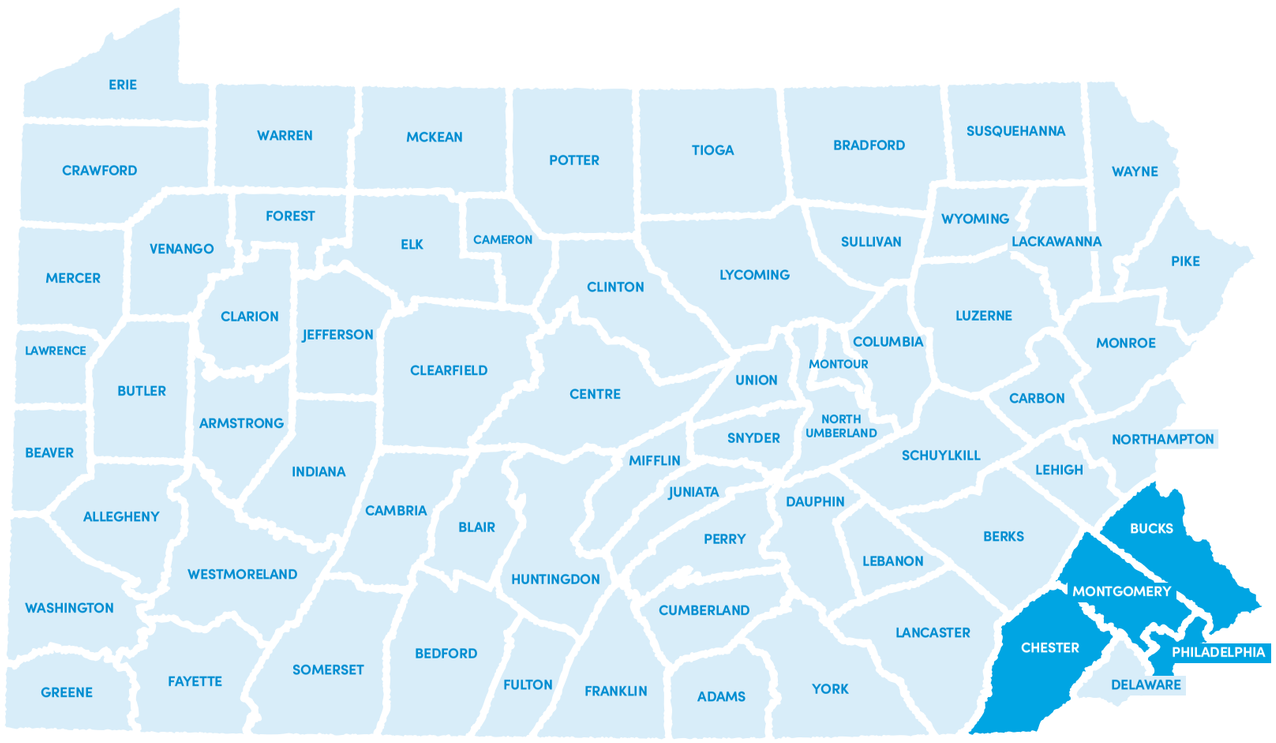
Previously Community Blue Medicare PPO Distinct

Premium MA plan with strong core medical and supplemental benefits in addition to national access through the BlueCard® Program.

- $0 Copay PCP IN; $0 – $10 Copay Lab IN
- $15 Copay Chiropractic IN
- Up to $2,500 Dental allowance
- $0 Tier 1 Drugs with no deductible

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

Complete Blue PPO Distinct — SEPA



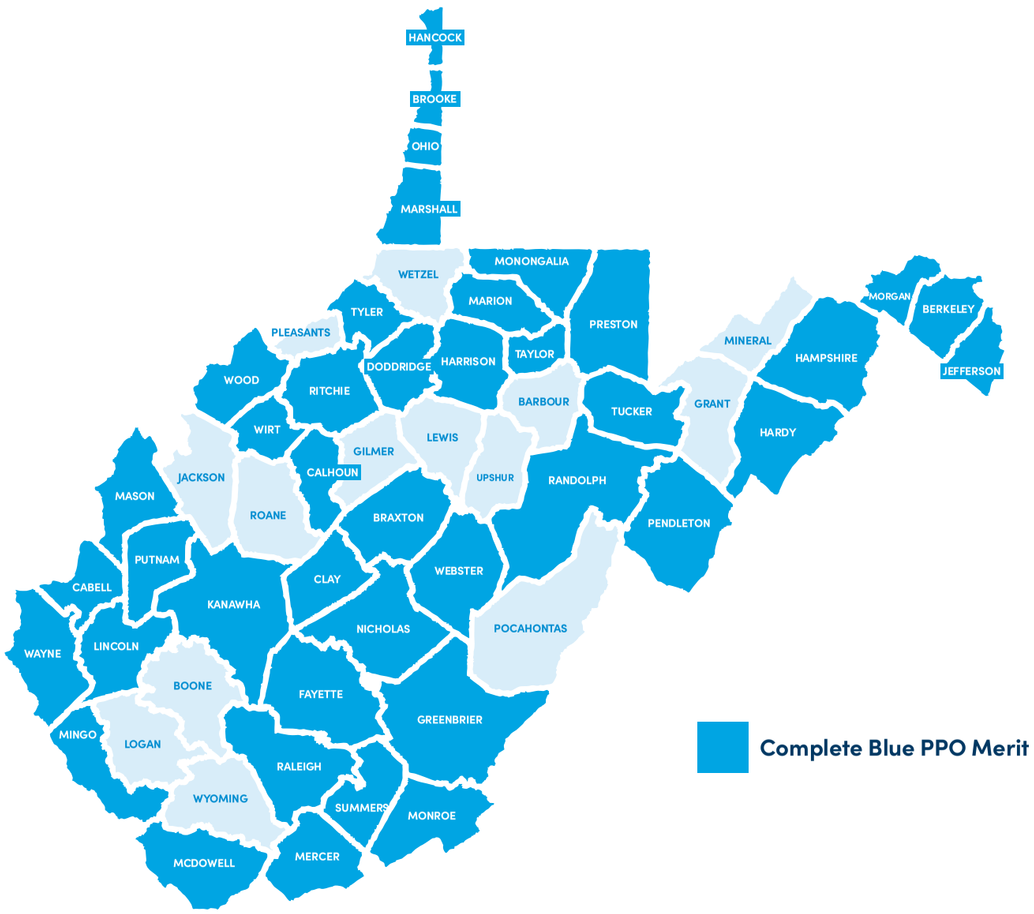
Complete Blue PPO Distinct

**Pricing is subject to CMS approval*

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

Monthly Plan Premium	$109
Part B Premium Giveback	$0
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: $9,550 OOP Max
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON
Specialist Office Visit	$40 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON
X-rays	$30 Copay IN; 40% Coinsurance OON
Radiation Therapy	$75 Copay IN; 40% Coinsurance OON
Advanced Imaging	$300 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	$35 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$35 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$35 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON
Outpatient Substance Abuse and Opioid Treatment Services	$45 Copay IN; 40% Coinsurance OON
Outpatient Surgical	ASC: $300 Copay IN; $350 Copay OON Facility: $350 Copay IN; $400 Copay OON
Ambulance	Emergent/Non-Emergent: $375 Copay 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	$130 Copay
Urgent Care	$50 Copay
Inpatient Hospital Stay	$275/day (days 1 – 7), $0/day (days 8 – 90) IN; $390/day (days 1 – 7), $0/day (days 8 – 90) 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
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories; 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON
Healing at Home	Not Covered
OTC Catalog	Not Covered
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
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
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% Coinsurance 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 or a $200 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	$40 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$15 Copay IN; $15 Copay OON (One every year)
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)
Medicare Covered Comprehensive Dental	$40 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500
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; 40% Coinsurance OON
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (four visits)
Medicare Covered Podiatry	$40 Copay IN; 40% Coinsurance OON
Routine Podiatry	$40 Copay IN; 40% Coinsurance OON (four visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON; Outpatient Blood: $0 Copay IN; 30% Coinsurance OON
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: $3, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 23%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 23%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy

Complete Blue PPO Merit — WV

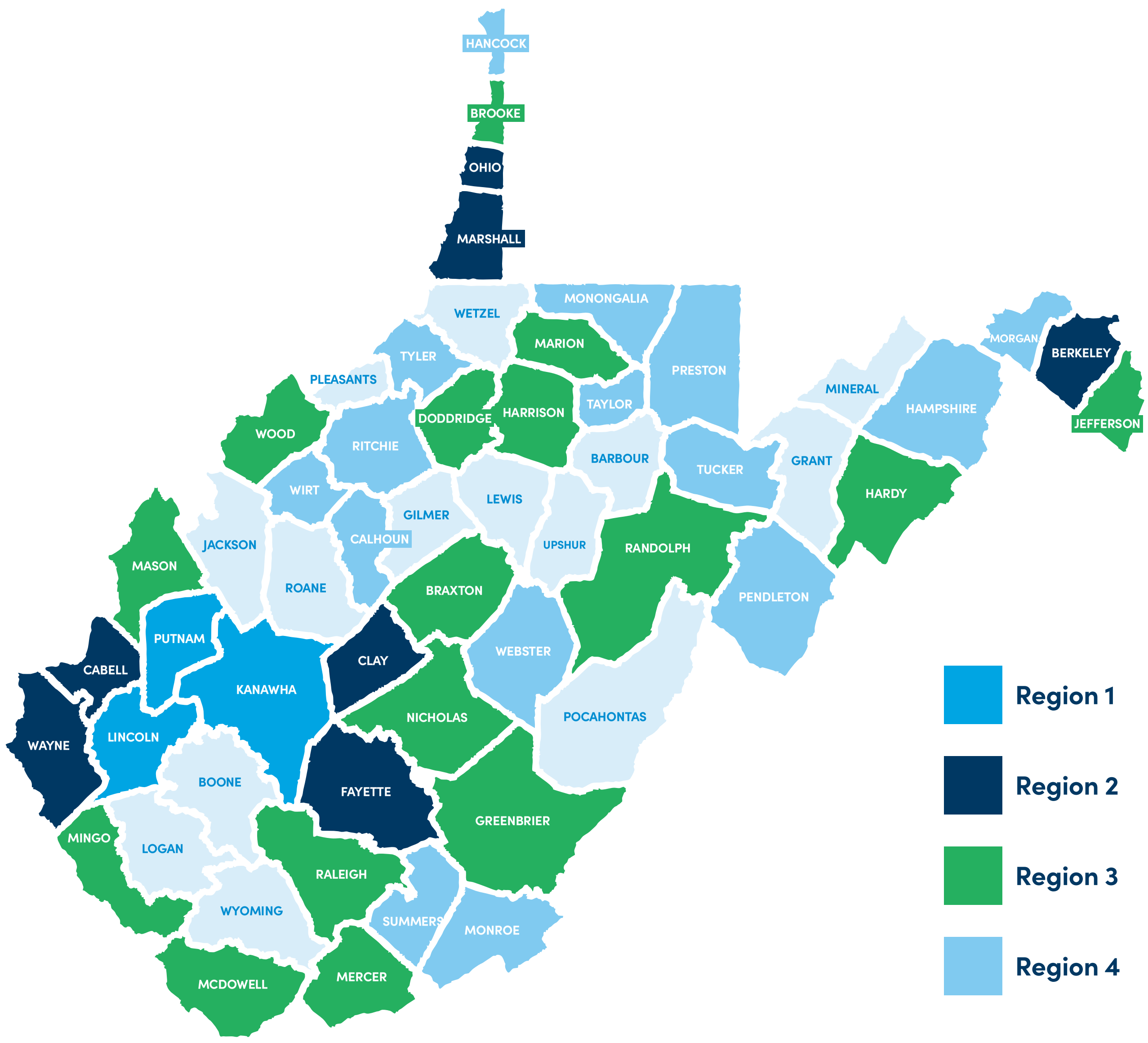


**Pricing is subject to CMS approval*

Complete Blue PPO Merit — WV (Products and pricing by county)

Monthly Plan Premium	$0
Part B Premium Giveback	$96
Out-of-Pocket Maximum	Network: $8,300 OOP Max; $13,000 OOP Max
Medical Deductible (+ indicates deductible applies before cost sharing)	$200
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON+
Specialist Office Visit	$50 Copay IN; 40% Coinsurance OON+
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay (lab) IN; $0 Copay (diagnostic) IN+; 40% Coinsurance OON+
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay (lab) IN; $10 Copay (diagnostic) IN+; 40% Coinsurance OON+
X-rays	$75 Copay IN+; 40% Coinsurance OON+ Deductible does not apply to diagnostic mammograms IN
Radiation Therapy	$60 Copay IN+; 40% Coinsurance OON +
Advanced Imaging	$300 Copay IN+; 40% Coinsurance OON+
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech Therapy	$25 Copay IN+; 40% Coinsurance OON+
Medicare Covered Acupuncture	$25 Copay IN+; 40% Coinsurance OON+
Outpatient Occupational Therapy	$25 Copay IN+; 40% Coinsurance OON+
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN+; 40% Coinsurance OON+
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN+; 40% Coinsurance OON+
Outpatient Surgical	ASC: $325 Copay IN+; $530 Copay OON+ Deductible does not apply to diagnostic colonoscopy IN Facility: $375 Copay IN+; $530 Copay OON+ Deductible does not apply to diagnostic colonoscopy IN
Ambulance	Emergent/Non-Emergent: $370 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	$115 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	$455/day (days 1 – 5), $0/day (days 6 – 90) IN+; $550/day (days 1 – 5), $0/day (days 6 – 90) OON+
Inpatient Psychiatry Stay	$645/day (days 1 – 3), $0/day (days 4 – 90) IN+; $720/day (days 1 – 7), $0/day (days 8 – 90) OON+
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON
Durable Medical Equipment	20% Coinsurance IN+; 40% Coinsurance OON+
Healing at Home	Not Covered
OTC Catalog	Not Covered
Meal Benefit	Not Covered
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
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)	$50 Copay IN; 40% Coinsurance 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 or a $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	$50 Copay IN; 40% Coinsurance OON+
Routine Hearing Exam	$40 Copay IN; $40 Copay OON (One every year)
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)
Medicare Covered Comprehensive Dental	$50 Copay IN; 40% Coinsurance OON+
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 50% Coinsurance IN. Adjunct general services: Palliative 0%, all others 50% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN+; 40% Coinsurance OON+
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (four visits)
Medicare Covered Podiatry	$50 Copay IN; 40% Coinsurance OON+
Routine Podiatry	$50 Copay IN; 40% Coinsurance OON (Eight visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $15 Copay IN+; 40% Coinsurance OON+ Partial Hospital/Intensive Outpatient Program Services: $60 Copay IN+; 40% Coinsurance OON+ Outpatient Blood: $0 Copay IN+; 30% Coinsurance OON+
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	The plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy

Complete Blue PPO Signature — WV

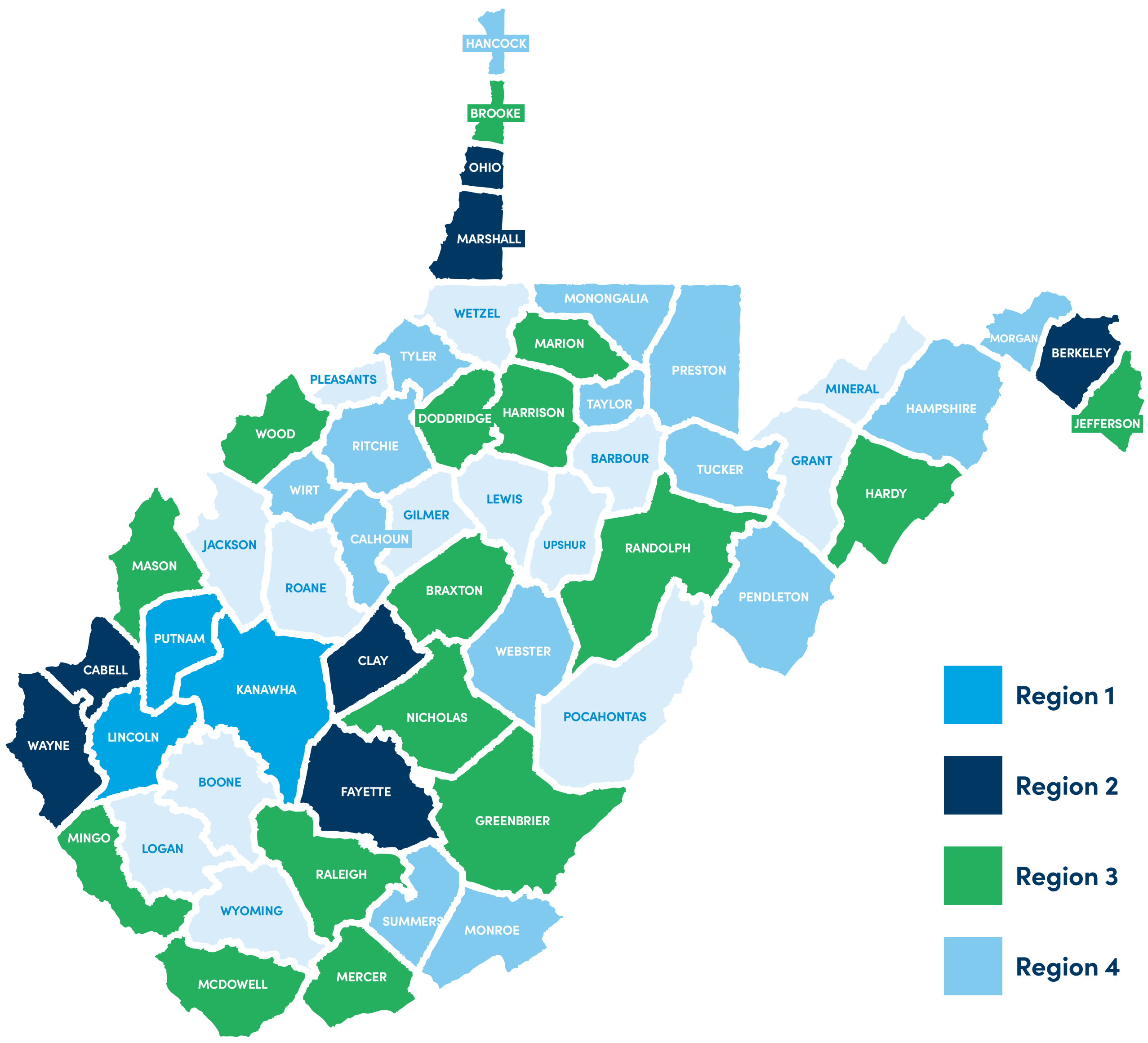


*Pricing is subject to CMS approval

Complete Blue PPO Signature — WV (Products and pricing by county)

	REGION 1	REGION 2	REGION 3	REGION 4
Monthly Plan Premium	$0			
Part B Premium Giveback	$5	$4	$6	$0
Out-of-Pocket Maximum	Network: $7,550 OOP Max; Combined: $10,000 OOP Max			
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON			
Specialist Office Visit	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$45 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON			
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON			
X-rays	$25 Copay IN; 40% Coinsurance OON			
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON			
Advanced Imaging	$250 Copay IN; 40% Coinsurance OON	$250 Copay IN; 40% Coinsurance OON	$250 Copay IN; 40% Coinsurance OON	$300 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON			
Outpatient Physical and Speech Therapy	$30 Copay IN; 40% Coinsurance OON			
Medicare Covered Acupuncture	$30 Copay IN; 40% Coinsurance OON			
Outpatient Occupational Therapy	$30 Copay IN; 40% Coinsurance OON			
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON			
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; 40% Coinsurance OON			
Outpatient Surgical	$250 Copay IN; $325 Copay OON	$250 Copay IN; $340 Copay OON	$250 Copay IN; $360 Copay OON	$300 Copay IN; $375 Copay OON
	$300 Copay IN; $375 Copay OON	$300 Copay IN; $390 Copay OON	$300 Copay IN; $410 Copay OON	$350 Copay IN; $425 Copay OON
Ambulance	Emergent/Non-Emergent: $200 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $200 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $200 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $560 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	$115 Copay			
Urgent Care	$40 Copay			
Inpatient Hospital Stay	$275/day (days 1 – 5), $0/day (days 6 – 90) IN; $425/day (days 1 – 5), $0/day (days 6 – 90) OON	$275/day (days 1 – 5), $0/day (days 6 – 90) IN; $425/day (days 1 – 5), $0/day (days 6 – 90) OON	$315/day (days 1 – 5), $0/day (days 6 – 90) IN; $425/day (days 1 – 5), $0/day (days 6 – 90) OON	$335/day (days 1 – 5), $0/day (days 6 – 90) IN; $425/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			
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON			
Durable Medical Equipment	20% Coinsurance IN; 40% Coinsurance OON			
Healing at Home	Not Covered			
OTC Catalog	$105 Allowance Once Per Quarter	$120 Allowance Once Per Quarter	$120 Allowance Once Per Quarter	$25 Allowance Once Per Quarter
Meal Benefit	Not Covered			
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON			
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; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$45 Copay IN; 40% Coinsurance 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 or a $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.			
Medicare Covered Hearing Exam	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$45 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$25 Copay IN; $25 Copay OON (One every year)			
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)			
Medicare Covered Comprehensive Dental	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$45 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	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.	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.	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.	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 50% Coinsurance IN.Adjunct general services: Palliative 0%, all others 50% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN; 40% Coinsurance OON			
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Eight visits)			
Medicare Covered Podiatry	$35 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$45 Copay IN; 40% Coinsurance OON
Routine Podiatry	$35 Copay IN; 40% Coinsurance OON (10 visits)	$35 Copay IN; 40% Coinsurance OON (10 visits)	$40 Copay IN; 40% Coinsurance OON (10 visits)	$45 Copay IN; 40% Coinsurance OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	Performance			
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615			
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: 19%, Tier 4: 20%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 19%, Tier 4: 20%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $0, Tier 3: 19%, Tier 4: 20%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 19%, Tier 4: 20%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $0, Tier 3: 19%, Tier 4: 20%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 19%, Tier 4: 20%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 22%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 22%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 19%, Tier 4: 20%, Tier 5: Not Covered	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 22%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 22%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31–day supply and $105 for 90-day supply at a retail or mail order pharmacy			

Complete Blue PPO Distinct — WV

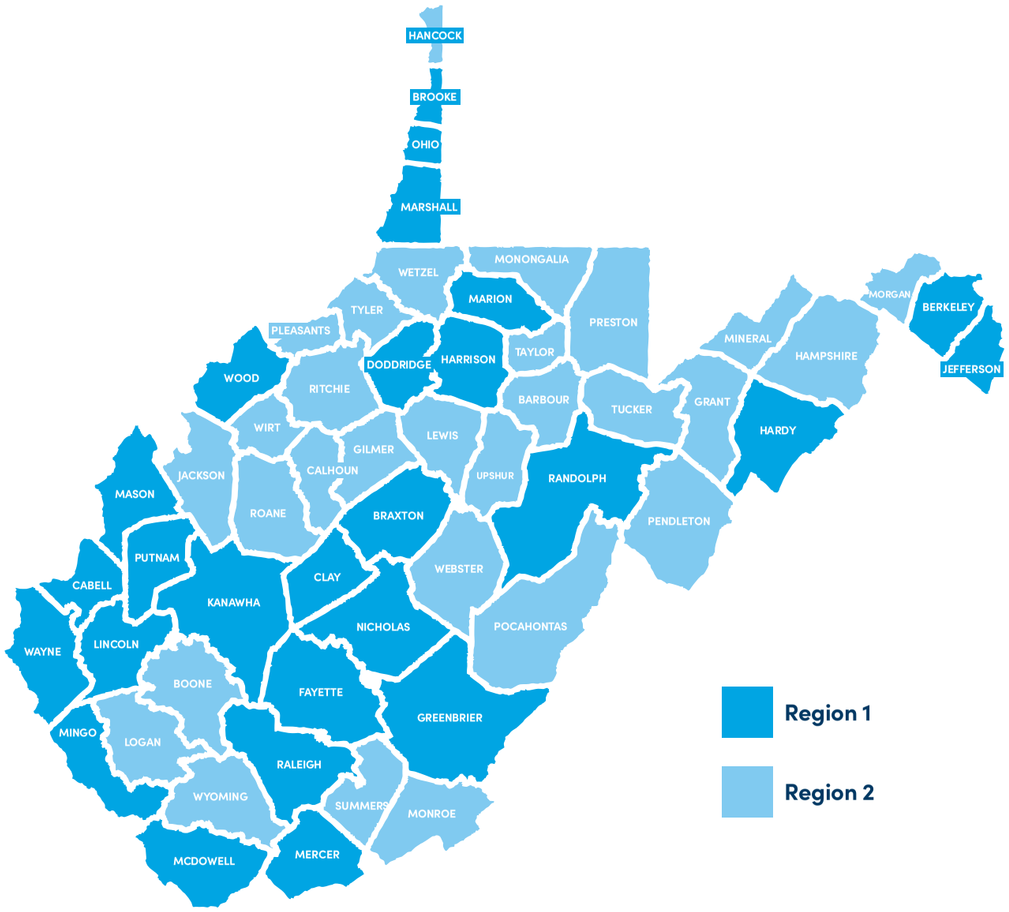


*Pricing is subject to CMS approval

Complete Blue PPO Distinct — WV (Products and pricing by county)

	REGION 1	REGION 2	REGION 3	REGION 4
Monthly Plan Premium	$25	$24	$24	$54
Part B Premium Giveback	$0			
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: $9,550 OOP Max			
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON			
Specialist Office Visit	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$50 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON			
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON			
X-rays	$15 Copay IN; 40% Coinsurance OON			
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON			
Advanced Imaging	$200 Copay IN; 40% Coinsurance OON			
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON			
Outpatient Physical and Speech Therapy	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON			
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; 40% Coinsurance OON			
Outpatient Surgical	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: $225 Copay IN; $350 Copay OON Facility: $300 Copay IN; $350 Copay OON	ASC: $275 Copay IN; $350 Copay OON Facility: $325 Copay IN; $375 Copay OON
Ambulance	Emergent/Non-Emergent: $365 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $270 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $270 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $535 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	$130 Copay			
Urgent Care	$40 Copay			
Inpatient Hospital Stay	$175/day (days 1 – 3), $0/day (days 4 – 90) IN; $500/day (days 1 – 4), $0/day (days 5-90) OON	$195/day (days 1 – 3), $0/day (days 4 – 90) IN; $500/day (days 1 – 4), $0/day (days 5-90) OON	$195/day (days 1 – 3), $0/day (days 4 – 90) IN; $500/day (days 1 – 4), $0/day (days 5-90) OON	$250/day (days 1 – 5), $0/day (days 6 – 90) IN; $500/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			
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON			
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON			
Healing at Home	Not Covered			
OTC Catalog	$40 Allowance Once Per Quarter	$40 Allowance Once Per Quarter	$40 Allowance Once Per Quarter	$50 Allowance Once Per Quarter
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			
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON			
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			
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; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance 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 or a $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.			
Medicare Covered Hearing Exam	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$25 Copay IN; $25 Copay OON (One every year)			
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)			
Medicare Covered Comprehensive Dental	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $2,500	Combined maximum allowance of $2,500	Combined maximum allowance of $2,500	Combined maximum allowance of $2,000
Comprehensive Dental — Supplemental	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: 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: 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: 50% Coinsurance IN. Adjunct general services: Palliative 0%, all others 50% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN; 40% Coinsurance OON			
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Eight visits)			
Medicare Covered Podiatry	$20 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$25 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON
Routine Podiatry	$20 Copay IN; 40% Coinsurance OON (10 visits)	$25 Copay IN; 40% Coinsurance OON (10 visits)	$25 Copay IN; 40% Coinsurance OON (10 visits)	$40 Copay IN; 40% Coinsurance OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON			
PART D DRUGS				
Formulary	Performance			
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615			
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: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%			
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $0, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%			
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Standard — WV



**Pricing is subject to CMS approval*

Freedom Blue PPO Standard — WV (Products and pricing by county)

	REGION 1	REGION 2
Monthly Plan Premium	$134	$154
Part B Premium Giveback	$0	
Out-of-Pocket Maximum	Network: $6,500 OOP Max; Combined: $10,000 OOP Max	
PCP Office Visit	$0 Copay IN; $0 Copay OON	
Specialist Office Visit	$35 Copay IN; $35 Copay OON	
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; $10 Copay OON	
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; $10 Copay OON	
X-rays	$25 Copay IN; $25 Copay OON	
Radiation Therapy	$60 Copay IN; $60 Copay OON	
Advanced Imaging	$75 Copay IN; $75 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	
Medicare Covered Acupuncture	$35 Copay IN; $35 Copay OON	
Outpatient Occupational Therapy	$35 Copay IN; $35 Copay OON	
Outpatient Mental Health and Psychiatric Therapy	$35 Copay IN; $35 Copay OON	
Outpatient Substance Abuse and Opioid Treatment Services	$35 Copay IN; $35 Copay OON	
Outpatient Surgical	ASC: $100 Copay IN; $100 Copay OON Facility: $150 Copay IN; $150 Copay OON	
Ambulance	Emergent/Non-Emergent: $330 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	$130 Copay	
Urgent Care	$50 Copay	
Inpatient Hospital Stay	$150/day (days 1 – 7) IN, $0/day (days 8 – 90) IN; $150/day (days 1 – 7), $0/day (days 8 – 90) OON	
Inpatient Psychiatry Stay	$150/day (days 1 – 7), $0/day (days 8 – 90) IN; $150/day (days 1 – 7), $0/day (days 8 – 90) OON	
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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	
Healing at Home	Not Covered	
OTC Catalog	Not Covered	
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	
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON	
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	
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	
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 or 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	
Routine Hearing Exam	$0 Copay IN; $35 Copay OON (One every year)	
Routine Hearing (Hearing Aids)	Two 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 (Two every year) Includes exam and cleaning X-ray: $15 Copay IN; 30% Coinsurance OON (One every year)	
Medicare Covered Comprehensive Dental	$35 Copay IN; $35 Copay OON	
Dental Allowance — Preventive and/or Comprehensive	N/A	
Comprehensive Dental — Supplemental	Adjunctive General Services (Palliative Only): 0% Coinsurance IN. Palliative Only: 30% Coinsurance OON. See EOC for benefit limits.	
Medicare Covered Chiropractic	$15 Copay IN; $15 OON	
Routine Chiropractic	$15 Copay IN; $15 OON (Eight visits)	
Medicare Covered Podiatry	$35 Copay IN; $35 OON	
Routine Podiatry	$35 Copay IN; $35 OON (10 visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	$0 Copay IN; 30% Coinsurance OON	
PART D DRUGS		
Formulary	Performance	
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: $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%	
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $27, Tier 3: $115, Tier 4: $275, Tier 5: 33% Standard Mail: Tier 1: $15, Tier 2: $57, Tier 3: $141, Tier 4: $300, Tier 5: 33%	
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy	

WV Growth Product Highlights

Complete Blue PPO Merit

Previously Freedom Blue PPO Merit

$0 MA plan with over $1,100 in annual Part B Givebacks and national BlueCard® access for the most cost-conscious consumer or low utilizers that don't want red tape when they need quality care.

- $96 Part B Premium Giveback
- $0 Copay PCP IN; $0 – $10 Lab IN
- $40 Copay Urgent Care
- $0 Tier 1 Drugs with no deductible

Complete Blue PPO Signature

Previously Freedom Blue PPO Signature

Fundamental $0 MA plan with strong core medical benefits, no deductible, a broad local network, and national access through the BlueCard® Program.

- $0 Copay PCP IN, $0 – $10 Lab IN
- $0 Copay Routine Dental office visits and X-Ray IN
- $2,000 Dental allowance
- $0 Tier 1 Drugs with no deductible

Complete Blue PPO Distinct

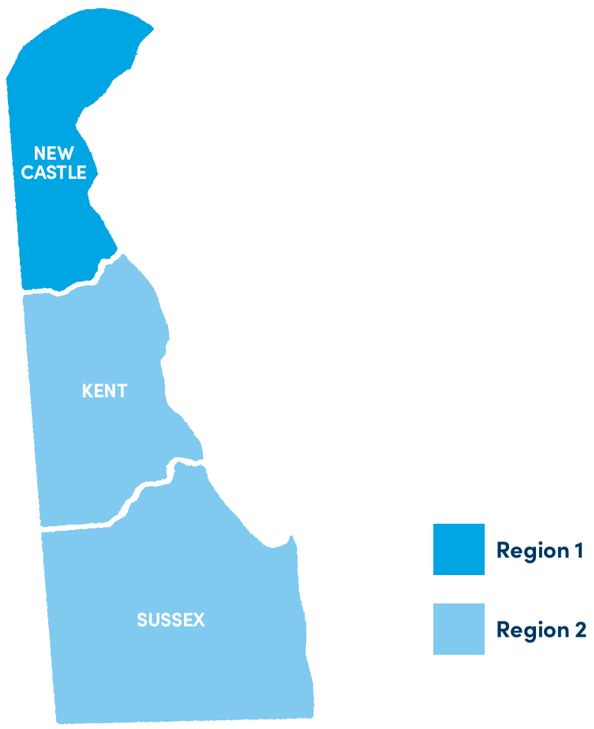
Previously Freedom Blue PPO Distinct

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

- $0 Copay PCP IN
- Up to $50 OTC allowance once per quarter
- Up to $2,500 Dental allowance with 10% coinsurance in most regions IN
- $0 Tier 1 and 2 Drugs with no deductible

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

Complete Blue PPO Signature and Distinct — DE

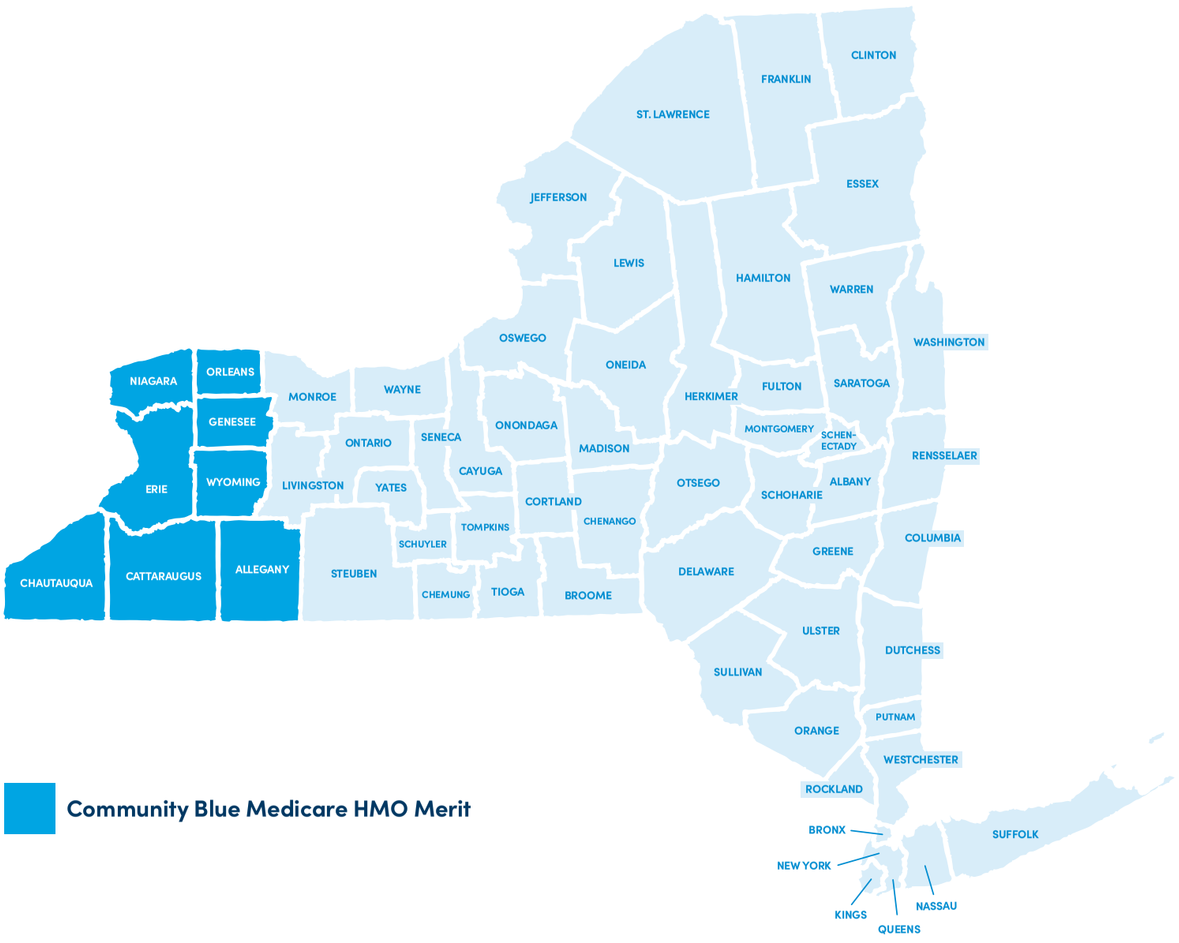


**Pricing is subject to CMS approval*

Complete Blue PPO Signature and Distinct – DE (Products and pricing by county)

	SIGNATURE — REGION 1	DISTINCT — REGION 1	DISTINCT — REGION 2
Monthly Plan Premium	$0	$105	$134
Part B Premium Giveback	$0	$0	$16
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: $10,000 OOP Max	Network: $6,500 OOP Max; Combined: $8,950 OOP Max	Network: $6,500 OOP Max; Combined: $8,950 OOP Max
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		
Specialist Office Visit	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$55 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON	$0 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON
X-rays	$25 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON		
Advanced Imaging	$350 Copay IN; 40% Coinsurance OON	$275 Copay IN; 40% Coinsurance OON	$300 Copay IN; 40% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON		
Outpatient Physical and Speech Therapy	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Medicare Covered Acupuncture	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$35 Copay IN; 40% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON	$30 Copay IN; 40% Coinsurance OON
Outpatient Surgical	ASC: $300 Copay IN; $400 Copay OON Facility: $350 Copay IN; $450 Copay OON	ASC: $275 Copay IN; $375 Copay OON Facility: $325 Copay IN; $425 Copay OON	ASC: $300 Copay IN; $375 Copay OON Facility: $350 Copay IN; $425 Copay OON
Ambulance	Emergent/Non-Emergent: $505 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $320 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $320 IN; Non-Emergent: 30% Coinsurance OON
Transportation	Not Covered		
Emergency Room	$130 Copay		
Urgent Care	$50 Copay		
Inpatient Hospital Stay	$375/day (days 1 – 7), $0/day (days 8 – 90) IN; $390/day (days 1 – 7), $0/day (days 8 – 90) OON	$325/day (days 1 – 5), $0/day (days 6 – 90) IN; $395/day (days 1 – 5), $0/day (days 6 – 90) OON	$355/day (days 1 – 5), $0/day (days 6 – 90) IN; $425/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		
Skilled Nursing Facility	$0/day (days 1 – 20); $218/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 Trividia, 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; 40% Coinsurance OON		
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		
Healing at Home	Not Covered		
OTC Catalog	$25 Allowance Once Per Quarter	Not Covered	Not Covered
Meal Benefit	Not Covered	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	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
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
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		
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)	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$55 Copay IN; 40% Coinsurance 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 or $150 benefit maximum for specialty contact lenses. $200 benefit maximum for post cataract eyewear.		Routine Eyewear Not Covered. IN/OON: $200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$55 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	$30 Copay IN; $30 Copay OON (One every year)	$0 Copay IN; $0 Copay OON (One every year)	Not Covered
Routine Hearing (Hearing Aids)	Two Hearing Aids Every year; TruHearing Advanced — $699 copay; TruHearing Premium — $999 copay IN; $500 allowance IN/OON for any other hearing aid		Not Covered
Routine Dental	Office Visit: $0 Copay IN; 30% Coinsurance OON (Two every year). Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		Not Covered
Medicare Covered Comprehensive Dental	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$55 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,000		Not Covered
Comprehensive Dental — Supplemental	Restorative, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 50% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-50% All Others IN; 50% Coinsurance OON. See EOC for benefit limits.		Not Covered
Medicare Covered Chiropractic	$15 Copay IN; 40% Coinsurance OON	$0 Copay IN; 40% Coinsurance OON	
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Eight visits)	$0 Copay IN; 40% Coinsurance OON (Eight visits)	
Medicare Covered Podiatry	$50 Copay IN; 40% Coinsurance OON	$40 Copay IN; 40% Coinsurance OON	$55 Copay IN; 40% Coinsurance OON
Routine Podiatry	$50 Copay IN; 40% Coinsurance OON (10 visits)	$40 Copay IN; 40% Coinsurance OON (10 visits)	$55 Copay IN; 40% Coinsurance OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		
PART D DRUGS			
Formulary	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.	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615 Preferred Retail: Tier 1: $0, Tier 2: $3, 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%	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615 Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $20, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	Tiers 1-Tier 5: $615 Preferred Retail: N/A Standard Retail: Tier 1: 25%, Tier 2: 25%, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, 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: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $60, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	Preferred Mail: N/A Standard Mail: Tier 1: 25%, Tier 2: 25%, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Merit — WNY

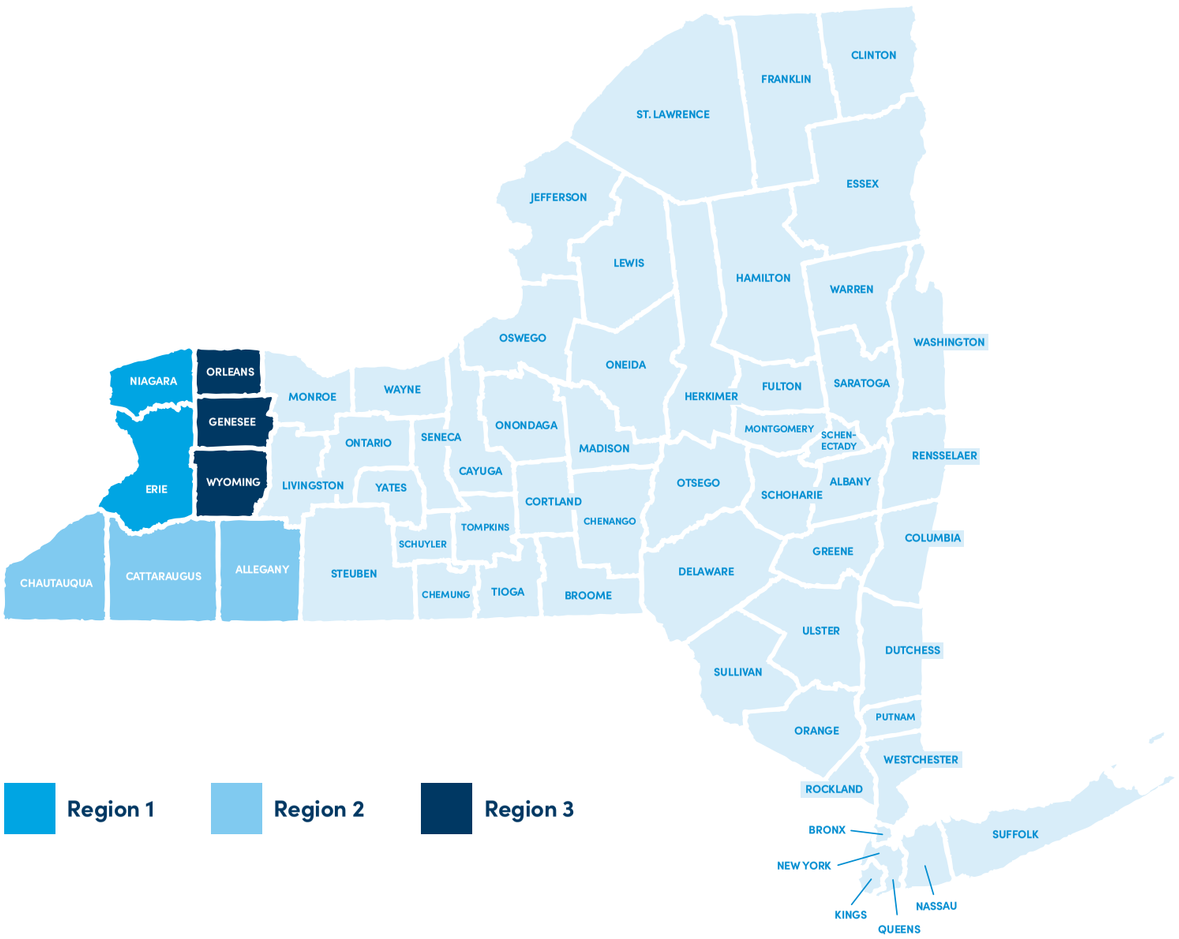


**Pricing is subject to CMS approval*

Community Blue Medicare HMO Merit – WNY (Products and pricing by county)

Monthly Plan Premium	$0
Part B Premium Giveback	$81
Out-of-Pocket Maximum	Network: $8,300 OOP Max; Combined: N/A
Medical Deductible (+ indicates deductible applies before cost sharing)	$250
PCP Office Visit	$0 Copay IN
Specialist Office Visit	$50 Copay IN
Lab and Diagnostic Tests (Freestanding Lab)	$10 Copay (lab) IN; $10 Copay (diagnostic) IN+
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$20 Copay (lab) IN; $20 Copay (diagnostic) IN+
X-rays	$50 Copay IN+
Radiation Therapy	20% Coinsurance IN+
Advanced Imaging	$300 Copay IN+
Preventive/Screening	$0 Copay IN
Outpatient Physical and Speech Therapy	$35 Copay IN+
Medicare Covered Acupuncture	$50 Copay IN+
Outpatient Occupational Therapy	$35 Copay IN+
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN+
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN+
Outpatient Surgical	ASC: $425 Copay IN+ Deductible does not apply to diagnostic colonoscopy IN Facility: $475 Copay IN+ Deductible does not apply to diagnostic colonoscopy IN
Ambulance	$450 Copay
Transportation	Not Covered
Emergency Room	$115 Copay
Urgent Care	$40 Copay
Inpatient Hospital Stay	$345/day (days 1 – 7), $0/day (days 8 – 90) IN+
Inpatient Psychiatry Stay	$295/day (days 1 – 7),$2,065 OOP Max per year IN+
Skilled Nursing Facility	$0 per day for days 1 – 20; $218 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 Abbott®. 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+
Healing at Home	Not Covered
OTC Catalog	Not Covered
Meal Benefit	$0 for 1 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.
Fitness Benefit	Covered in Full
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
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)
Routine Vision (Office Visit)	$0 Copay IN (One every year)
Routine Vision (Eyewear)	$100 Allowance for routine eyewear Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	$50 Copay IN
Routine Hearing Exam	$45 Copay IN (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 Per Service IN; (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay Per Service IN (One every year)
Medicare Covered Comprehensive Dental	$50 Copay IN
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 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)
Medicare Covered Podiatry	$50 Copay IN
Routine Podiatry	$50 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $10 Copay IN+ Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN+ Outpatient Blood: $0 Copay+
PART D DRUGS	
Formulary	Performance
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615
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: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $17, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $51, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Signature — WNY

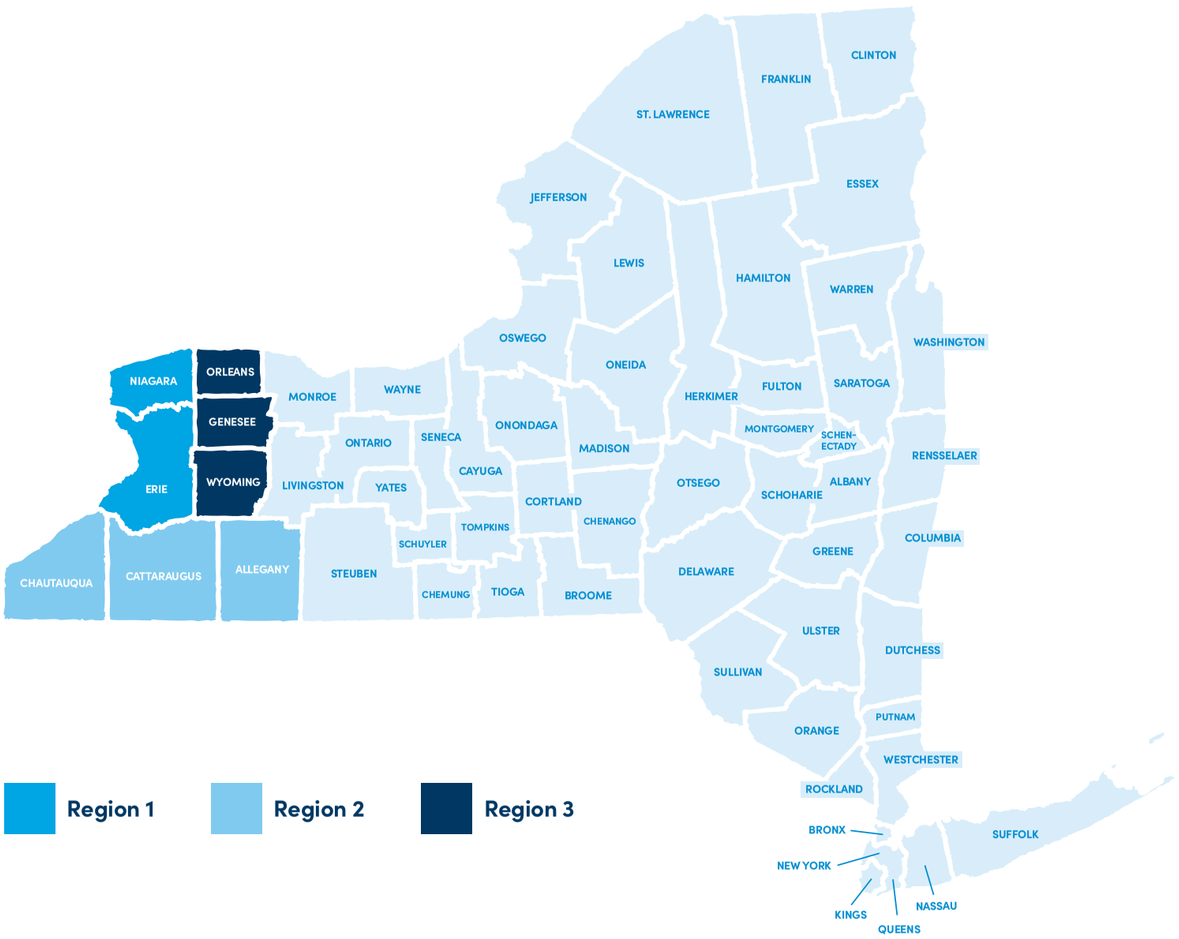


**Pricing is subject to CMS approval*

Community Blue Medicare HMO Signature – WNY (Products and pricing by county)

	REGION 1	REGION 2	REGION 3
Monthly Plan Premium	$0		
Part B Premium Giveback	$2		
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: N/A		
PCP Office Visit	$0 Copay IN		
Specialist Office Visit	$40 Copay IN	$40 Copay IN	$55 Copay IN
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN		
X-rays	$25 Copay IN	$45 Copay IN	$45 Copay IN
Radiation Therapy	20% Coinsurance IN		
Advanced Imaging	$200 Copay IN	$250 Copay IN	$300 Copay IN
Preventive/Screening	$0 Copay IN		
Outpatient Physical and Speech Therapy	$30 Copay IN	$35 Copay IN	
Medicare Covered Acupuncture	$40 Copay IN	$40 Copay IN	$55 Copay IN
Outpatient Occupational Therapy	$30 Copay IN	$35 Copay IN	
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN		
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN		
Outpatient Surgical	ASC: $275 Copay IN Facility: $375 Copay IN	ASC: $325 Copay IN Facility: $425 Copay IN	ASC: $350 Copay IN Facility: $450 Copay IN
Ambulance	$390 Copay		
Transportation	Not Covered		
Emergency Room	$130 Copay		
Urgent Care	$40 Copay		
Inpatient Hospital Stay	$350/day (days 1 – 6), $0/day (days 7 – 90)	$395/day (days 1 – 6), $0/day (days 7 – 90)	$400/day (days 1 – 6), $0/day (days 7 – 90)
Inpatient Psychiatry Stay	$405 per day for days 1 – 4, $1,620 OOP Max per year		
Skilled Nursing Facility	$0 per day for days 1 – 20; $218 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 Abbott®. 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% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.		
Healing at Home	Not Covered		
OTC Catalog	$75 quarterly allowance		
Meal Benefit	$0 for 1 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.		
Fitness Benefit	Covered in Full		
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		
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)	$40 (except $0 for diabetic retinal eye exam)	$40 (except $0 for diabetic retinal eye exam)	$55 (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)	$100 Allowance for routine eyewear Benefit is carved out to Davis Vision		
Medicare Covered Hearing Exam	$40 Copay IN	$40 Copay IN	$55 Copay IN
Routine Hearing Exam	$45 Copay IN (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 IN; (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay IN (One every year)		
Medicare Covered Comprehensive Dental	$40 Copay IN	$40 Copay IN	$55 Copay IN
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $1,500	Combined maximum allowance of $1,500	Combined maximum allowance of $1,000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 50% Coinsurance. Adjunct general services: Palliative 0%, all others 50% Coinsurance. See EOC for benefit limits.		
Medicare Covered Chiropractic	$15 Copay IN		
Routine Chiropractic	$15 Copay IN (six per plan year)		
Medicare Covered Podiatry	$40 Copay IN	$40 Copay IN	$55 Copay IN
Routine Podiatry	$40 Copay IN (three visits)	$40 Copay IN (three visits)	$55 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $10 Copay IN Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN Outpatient Blood: $0 Copay		
PART D DRUGS			
Formulary	Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $5, Tier 2: $20, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%		
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $15, Tier 2: $60, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%		
OOP Threshold	$2,100. 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. Excludes Deductible.	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 Distinct — WNY

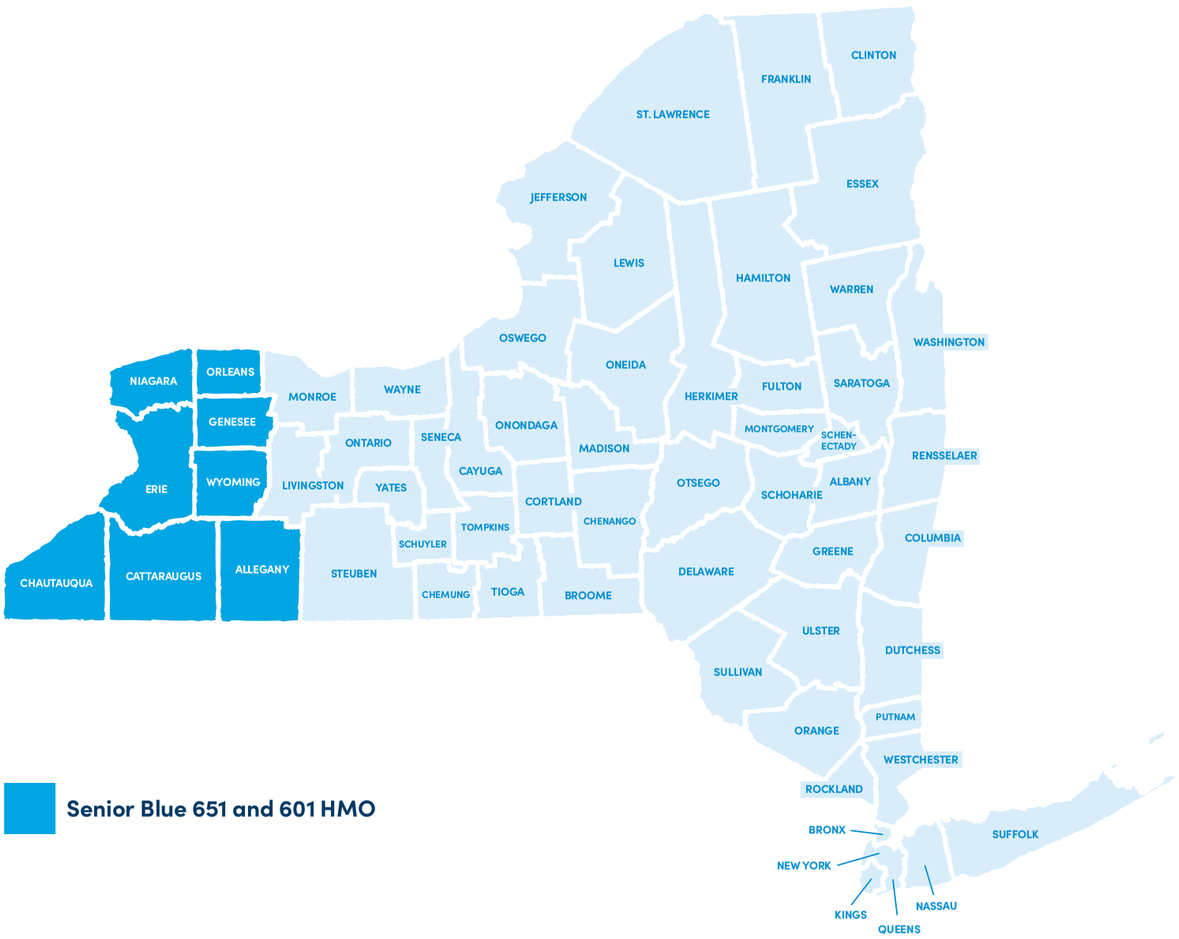


**Pricing is subject to CMS approval*

Community Blue Medicare HMO Distinct – WNY (Products and pricing by county)

	REGION 1	REGION 2	REGION 3
Monthly Plan Premium	$49	$55	$59
Part B Premium Giveback	$0		
Out-of-Pocket Maximum	Network: $6,750 OOP Max; Combined: N/A		
PCP Office Visit	$0 Copay IN		
Specialist Office Visit	$30 Copay IN	$30 Copay IN	$35 Copay IN
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN		
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN		
X-rays	$45 Copay IN		
Radiation Therapy	20% Coinsurance IN		
Advanced Imaging	$175 Copay IN	$225 Copay IN	$225 Copay IN
Preventive/Screening	$0 Copay IN		
Outpatient Physical and Speech Therapy	$25 Copay IN		
Medicare Covered Acupuncture	$30 Copay IN	$30 Copay IN	$35 Copay IN
Outpatient Occupational Therapy	$25 Copay IN		
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN		
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN		
Outpatient Surgical	ASC: $250 Copay IN Facility: $350 Copay IN	ASC: $275 Copay IN Facility: $375 Copay IN	ASC: $300 Copay IN Facility: $400 Copay IN
Ambulance	$395 Copay		
Transportation	Not Covered		
Emergency Room	$130 Copay		
Urgent Care	$40 Copay		
Inpatient Hospital Stay	$345/day (days 1 – 5), $0/day (days 6 – 90)	$345/day (days 1 – 6), $0/day (days 7 – 90)	$345/day (days 1 – 6), $0/day (days 7 – 90)
Inpatient Psychiatry Stay	$260 per day for days 1 – 6, $1,560 OOP Max per year		
Skilled Nursing Facility	$0 per day for days 1 – 20; $218 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 Abbott®. 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% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.		
Healing at Home	Not Covered		
OTC Catalog	$55 quarterly allowance	$55 quarterly allowance	$50 quarterly allowance
Meal Benefit	$0 for 1 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.		
Fitness Benefit	Covered in Full		
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		
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)	$30 (except $0 for diabetic retinal eye exam)	$30 (except $0 for diabetic retinal eye exam)	$35 (except $0 for diabetic retinal eye exam)
Routine Vision (Office Visit)	$0 Copay IN (One every year)	$0 Copay IN (One every year)	$10 Copay IN (One every year)
Routine Vision (Eyewear)	$200 Allowance for routine eyewear Benefit is carved out to Davis Vision		
Medicare Covered Hearing Exam	$30 Copay IN	$30 Copay IN	$35 Copay IN
Routine Hearing Exam	$25 Copay IN (One every year)	$25 Copay IN (One every year)	$35 Copay IN (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 IN (Two every year) Includes exam and cleaning X-ray: $0 Copay IN (One every year)		
Medicare Covered Comprehensive Dental	$30 Copay IN	$30 Copay IN	$35 Copay IN
Dental Allowance — Preventive and/or Comprehensive	Comprehensive maximum allowance of $2,000		
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery: 50% Coinsurance. Adjunct general services: Palliative 0%, all others 50% Coinsurance. See EOC for benefit limits.		
Medicare Covered Chiropractic	$15 Copay IN		
Routine Chiropractic	$15 Copay IN (12 per plan year)		
Medicare Covered Podiatry	$30 Copay IN	$30 Copay IN	$35 Copay IN
Routine Podiatry	$30 Copay IN (three visits)	$30 Copay IN (three visits)	$35 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/ Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $15 Copay IN Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN Outpatient Blood: $0 Copay		
PART D DRUGS			
Formulary	Performance		
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615		
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: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%		
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%		
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy		

Senior Blue 651 and 601 HMO — WNY

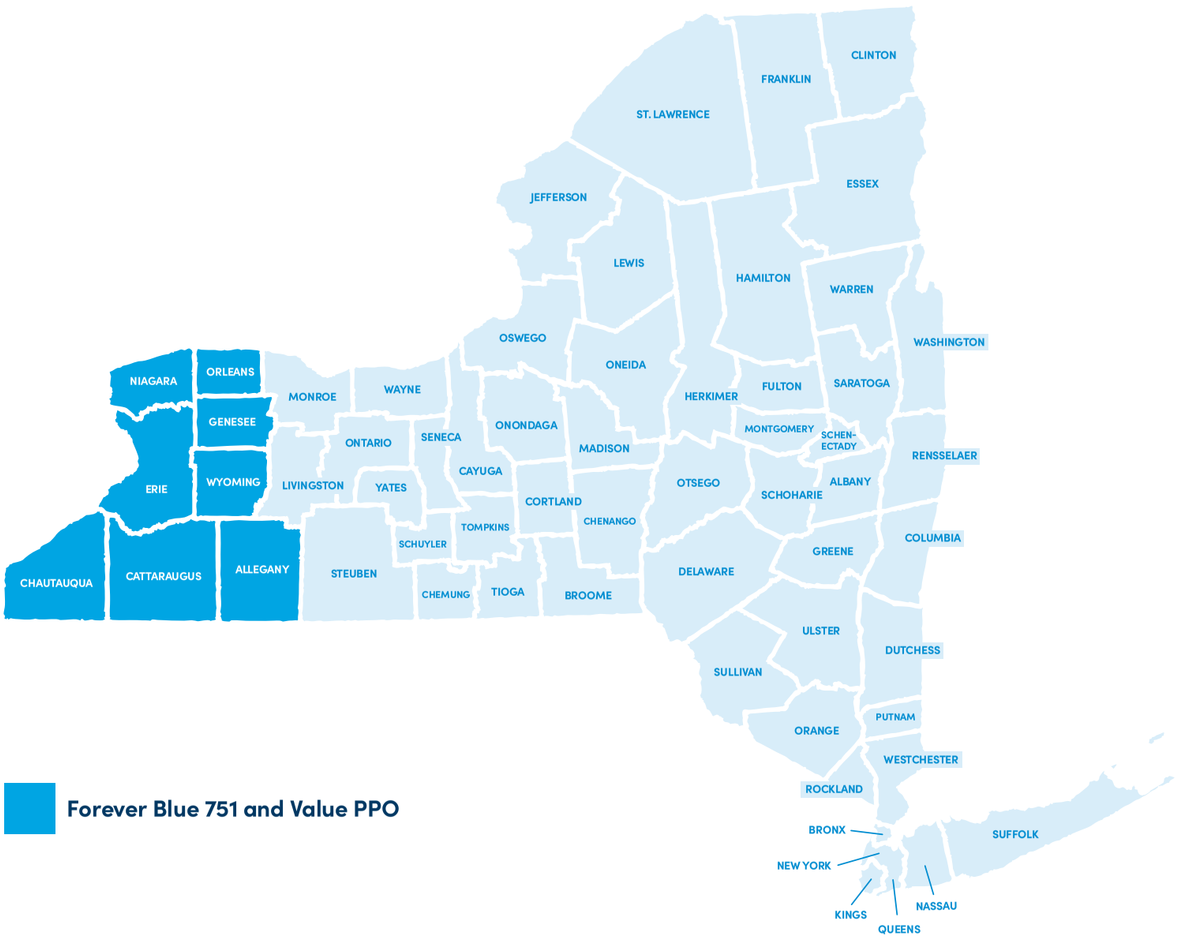


**Pricing is subject to CMS approval*

Senior Blue 651 and 601 HMO – WNY (Products and pricing by county)

	SENIOR BLUE 651	SENIOR BLUE 601
Monthly Plan Premium	$97	$0
Part B Premium Giveback	$0	
Out-of-Pocket Maximum	Network: $6,700 OOP Max; Combined: N/A	
PCP Office Visit	$0 Copay IN	$0 -$5 Copay IN
Specialist Office Visit	$25 Copay IN	$45 Copay IN
Lab and Diagnostic Tests (Freestanding Lab)	$5 Lab Copay IN; $40 Diagnostic test IN	$0 Lab Copay IN; $45 Diagnostic test IN
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$5 Lab Copay IN; $40 Diagnostic test IN	$0 Lab Copay IN; $45 Diagnostic test IN
X-rays	$40 Copay IN	$45 Copay IN
Radiation Therapy	20% Coinsurance IN	
Advanced Imaging	$150 Copay IN	
Preventive/Screening	$0 Copay IN	
Outpatient Physical and Speech Therapy	$15 Copay IN	
Medicare Covered Acupuncture	$25 Copay IN	$45 Copay IN
Outpatient Occupational Therapy	$15 Copay IN	
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN	
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN	
Outpatient Surgical	ASC: $225 Copay IN; Facility: $325 Copay IN	
Ambulance	$200 Copay	$300 Copay
Transportation	Not Covered	
Emergency Room	$130 Copay	
Urgent Care	$50 Copay	
Inpatient Hospital Stay	$225 per day for days 1 – 7, $1,575 OOP Max per year	$290 per day for days 1 – 7, $2,030 OOP Max per year
Inpatient Psychiatry Stay	$215 per day for days 1 – 6, $1,290 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; $218 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 Abbott®. 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	
Healing at Home	Not Covered	
OTC Catalog	$40 quarterly allowance	$25 quarterly allowance
Meal Benefit	$0 for 1 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.	
Fitness Benefit	Covered in Full	
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	
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)	$25 (except $0 for diabetic retinal eye exam)	$45 (except $0 for diabetic retinal eye exam)
Routine Vision (Office Visit)	$25 Copay IN (One every year)	$0 Copay IN (One every year)
Routine Vision (Eyewear)	$200 Allowance for routine eyewear Benefit is carved out to Davis Vision	$100 Allowance for routine eyewear Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	$25 Copay IN	$45 Copay IN
Routine Hearing Exam	$45 Copay IN (One every year)	
Routine Hearing (Hearing Aids)	Two Hearing Aids Every year; TruHearing Advanced — $499 copay; TruHearing Premium — $799 copay	Two Hearing Aids Every year; TruHearing Advanced — $599 copay; TruHearing Premium — $899 copay
Routine Dental	Office Visit: $0 Copay IN (Two every year) Includes exam and cleaning X-ray: $0 Copay IN (One every year)	
Medicare Covered Comprehensive Dental	$25 Copay IN	$45 Copay IN
Dental Allowance — Preventive and/or Comprehensive	Comprehensive maximum allowance of $2,000	
Comprehensive Dental — Supplemental	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 Not Covered). Adjunct general services (Palliative only): 50% Coinsurance. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN	
Routine Chiropractic	$15 Copay IN (12 per plan year)	$15 Copay IN (six per plan year)
Medicare Covered Podiatry	$25 Copay IN	$45 Copay IN
Routine Podiatry	$25 Copay IN (three visits)	$45 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $15 Copay IN Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN Outpatient Blood: $0 Copay	
PART D DRUGS		
Formulary	Fundamental	Not Covered
	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615	N/A
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: $3, Tier 3: 20%, Tier 4: 20%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 20%, Tier 5: 25%	N/A
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 20%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 20%, Tier 5: 25%	N/A
OOP Threshold	$2,100. Once that is met, the plan pays the full cost for covered Part D drugs.	N/A
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy	N/A

Forever Blue 751 and Value PPO — WNY



**Pricing is subject to CMS approval*

Forever Blue 751 and Value PPO – WNY (Products and pricing by county)

	FOREVER BLUE 751 (PPO)	FOREVER BLUE VALUE (PPO)
Monthly Plan Premium	$210	$152
Part B Premium Giveback	$0	
Out-of-Pocket Maximum	Network: $6,700 OOP Max; Combined: $10,000 OOP Max	
PCP Office Visit	$0–$5 Copay IN; 25% Coinsurance OON	$0–$10 Copay IN; 35% Coinsurance OON
Specialist Office Visit	$25 Copay IN; 25% Coinsurance OON	$30 Copay IN; 35% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$5 Lab Copay IN; $40 Diagnostic Tests; Both 25% Coinsurance OON	$5 Lab Copay IN; $45 Diagnostic Tests IN; Both 35% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$5 Lab Copay IN; $40 Diagnostic Tests; Both 25% Coinsurance OON	$5 Lab Copay IN; $45 Diagnostic Tests IN; Both 35% Coinsurance OON
X-rays	$40 Copay IN; 25% Coinsurance OON	$45 Copay IN; 35% Coinsurance OON
Radiation Therapy	20% Coinsurance IN; 25% Coinsurance OON	20% Coinsurance IN; 35% Coinsurance OON
Advanced Imaging	$150 Copay IN; 25% Coinsurance OON	$150 Copay IN; 35% Coinsurance OON
Preventive/Screening	$0 Copay IN; 25% Coinsurance OON	$0 Copay IN; 35% Coinsurance OON
Outpatient Physical and Speech Therapy	$20 Copay IN; 25% Coinsurance OON	$20 Copay IN; 35% Coinsurance OON
Medicare Covered Acupuncture	$25 Copay IN; 25% Coinsurance OON	$30 Copay IN; 35% Coinsurance OON
Outpatient Occupational Therapy	$20 Copay IN; 25% Coinsurance OON	$20 Copay IN; 35% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN; 50% Coinsurance OON	
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN; 50% Coinsurance OON	
Outpatient Surgical	ASC: $200 Copay IN; 25% Coinsurance OON Facility: $300 Copay IN; 25% Coinsurance OON	ASC: $250 Copay IN; 35% Coinsurance OON Facility: $350 Copay IN; 35% Coinsurance OON
Ambulance	$225 Copay	$320 Copay
Transportation	Not Covered	
Emergency Room	$130 Copay	
Urgent Care	$50 Copay	
Inpatient Hospital Stay	$205 per day for days 1 – 7, $1,435 OOP Max per year IN; 30% Coinsurance OON	$295 per day for days 1 – 7, $2,065 OOP Max per year IN; 35% Coinsurance OON
Inpatient Psychiatry Stay	$270 per day for days 1 – 6, $1,620 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
Skilled Nursing Facility	$0 per day for days 1 – 20; $218 per day for days 21 – 100. No yearly benefit period maximum IN; 30% Coinsurance OON	$0 per day for days 1 – 20; $218 per day for days 21 – 100. No yearly benefit period maximum IN; 35% Coinsurance OON
Home Health	$0 Copay IN; 25% Coinsurance OON	$0 Copay IN; 35% 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 Abbott®. 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	
Healing at Home	Not Covered	
OTC Catalog	$40 quarterly allowance	
Meal Benefit	$0 for 1 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.	
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON	
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 IN; 25% Coinsurance OON	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 35% 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 (except $0 for diabetic retinal eye exam); 25% Coinsurance OON	$30 (except $0 for diabetic retinal eye exam); 35% Coinsurance OON
Routine Vision (Office Visit)	$25 Copay IN; 20% Coinsurance OON (One every year)	
Routine Vision (Eyewear)	$200 IN and OON Combined; Benefit is carved out to Davis Vision	
Medicare Covered Hearing Exam	$25 Copay IN; 25% Coinsurance OON	$30 Copay IN; 35% Coinsurance OON
Routine Hearing Exam	$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 Visit: $0 Copay IN; $0 Copay OON (Two every year) Includes exam, and cleaning X-ray: $0 Copay IN; $0 Copay OON (One every year)	
Medicare Covered Comprehensive Dental	$25 Copay IN; 25% Coinsurance OON	$30 Copay IN; 35% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Comprehensive maximum allowance of $2,000	
Comprehensive Dental — Supplemental	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.	
Medicare Covered Chiropractic	$15 Copay IN; 25% Coinsurance OON	$15 Copay IN; 35% Coinsurance OON
Routine Chiropractic	$15 Copay IN; 25% Coinsurance OON (12 per plan year)	$15 Copay IN; 35% Coinsurance OON (12 per plan year)
Medicare Covered Podiatry	$25 Copay IN; 25% Coinsurance OON	$30 Copay IN; 35% Coinsurance OON
Routine Podiatry	$25 Copay IN; 25% Coinsurance OON (three visits)	$30 Copay IN; 35% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $15 Copay IN; 25% Coinsurance OON Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN; 25% Coinsurance OON Outpatient Blood: $0 Copay IN; 25% Coinsurance OON	Cardiac and Pulmonary Rehab and SET: $5 Copay IN; 35% Coinsurance OON Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN; 3 5% Coinsurance OON Outpatient Blood: $0 Copay IN; 35% Coinsurance OON
PART D DRUGS		
Formulary	Fundamental	
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615	
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: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy	

WNY Growth Product Highlights

Community Blue Medicare HMO Merit

Previously Senior Blue Basic HMO

$0 MA plan with a high monthly Part B giveback for the most cost-conscious consumer or low utilizers.

- $81 Part B Premium Giveback
- $0 Copay PCP
- $1,500 Dental allowance
- $0 Tier 1 Drugs with no deductible

Community Blue Medicare HMO Signature

Previously BlueSaver HMO

$0 MA plan with strong core medical and supplemental benefits.

- $0 Copay PCP; $0 – $10 Copay Lab
- Up to $1,500 Dental allowance
- $0 Tier 1 Drugs with no deductible

Community Blue Medicare HMO Distinct

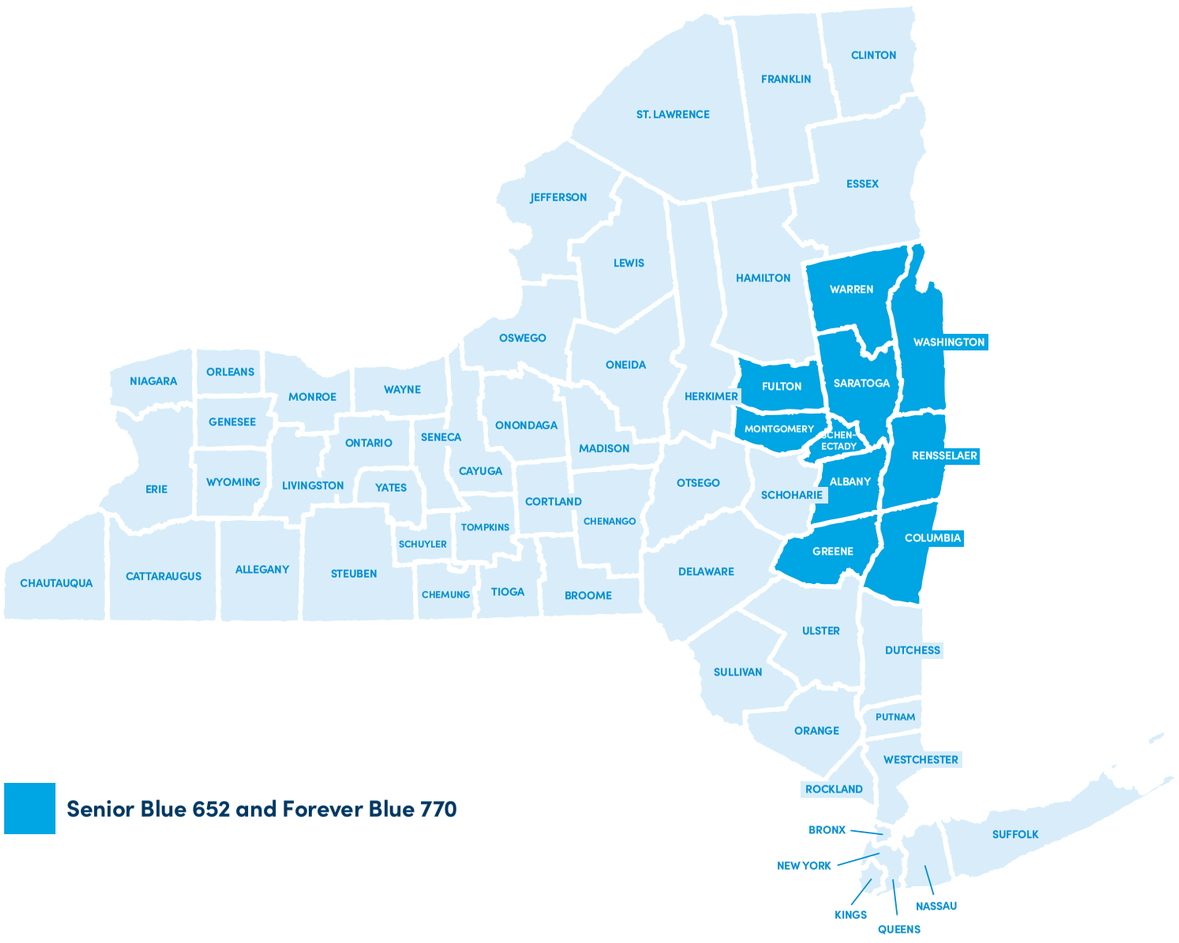
Previously Senior Blue Select HMO

Premium MA plan with rich medical and more robust supplemental benefits offering predictability.

- $0 Copay PCP; $0 – $10 Copay Lab
- $55 OTC quarterly allowance in most regions
- $2,000 Dental allowance
- $0 Tier 1 Drugs with no deductible

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

Senior Blue 652 and Forever Blue 770 — NENY

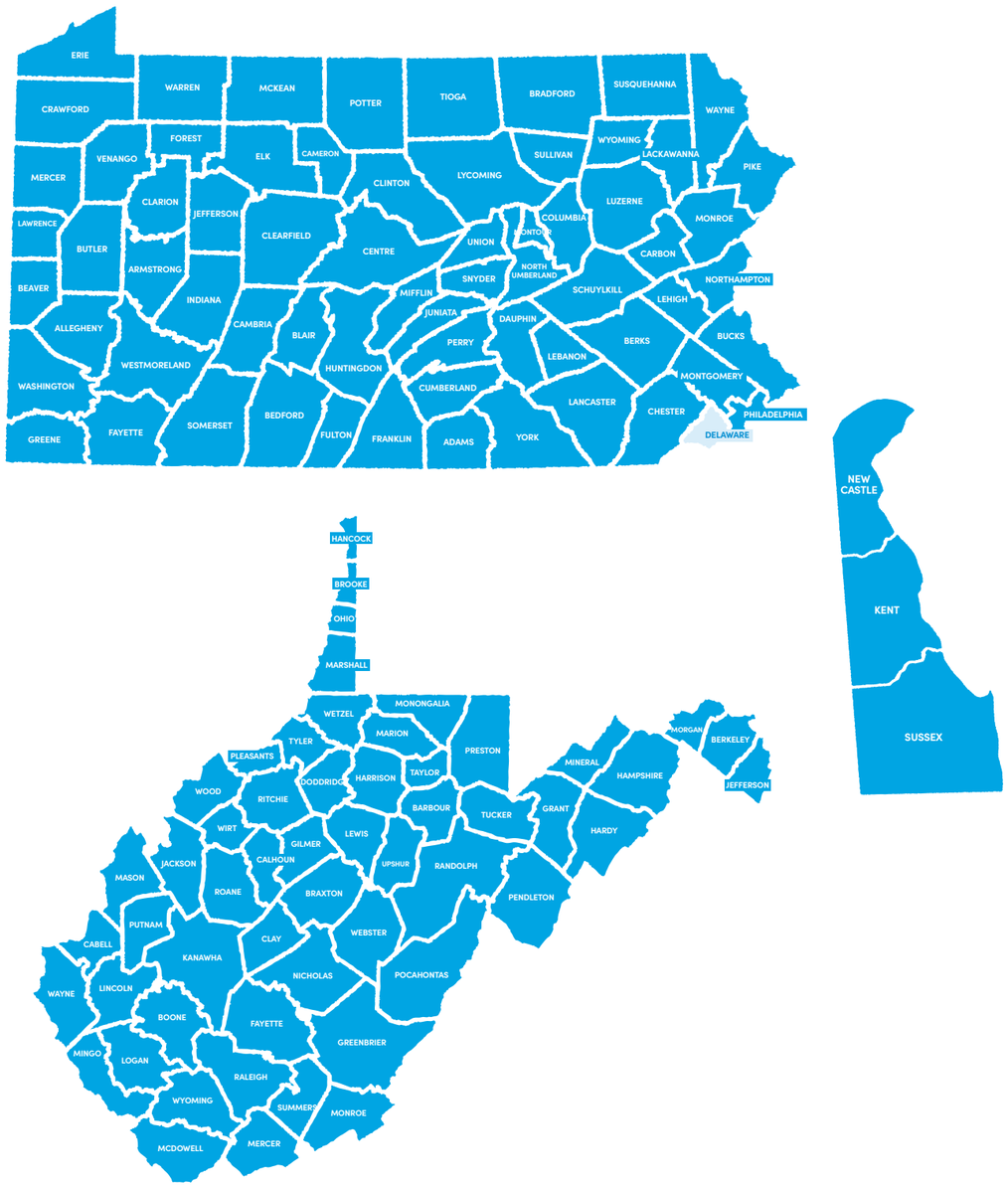


**Pricing is subject to CMS approval*

Senior Blue 652 and Forever Blue 770 — NENY (Products and pricing by county)

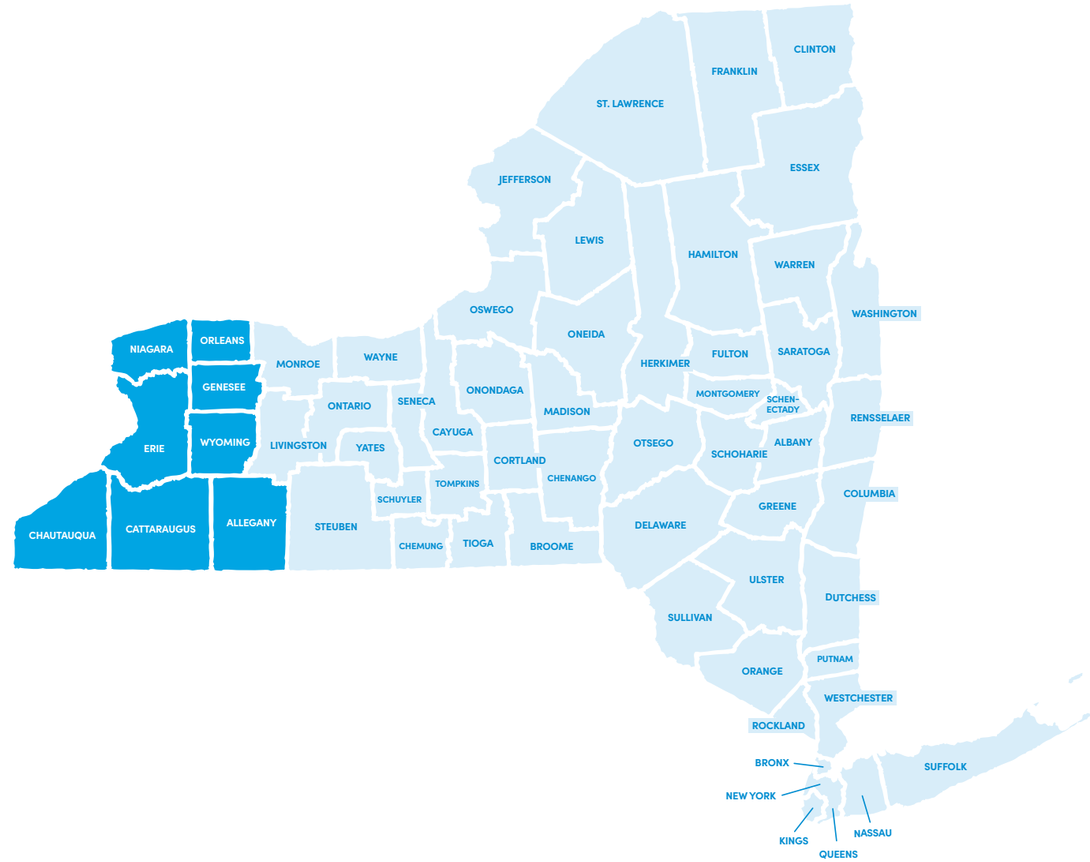
	SENIOR BLUE 652 (HMO)	FOREVER BLUE 770 (PPO)
Monthly Plan Premium	$104	$220
Part B Premium Giveback	$0	$0
Out-of-Pocket Maximum	Network: $6,700 OOP Max; Combined: N/A	Network: $6,700 OOP Max; Combined: $10,000 OOP Max
PCP Office Visit	$0 Copay IN	$0–$5 Copay IN; 25% Coinsurance OON
Specialist Office Visit	$26 Copay IN	$22 Copay IN; 25% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$5 lab Copay IN; $50 diagnostic test copay IN	$5 lab Copay IN; $5 copay OON; $40 diagnostic test copay IN; 25% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$5 lab Copay IN; $50 diagnostic test copay IN	$5 lab Copay IN; $5 copay OON; $40 diagnostic test copay IN; 25% Coinsurance OON
X-rays	$50 Copay IN	$40 Copay IN; 25% Coinsurance OON
Radiation Therapy	20% Coinsurance IN	20% Coinsurance IN; 25% Coinsurance OON
Advanced Imaging	$150 Copay IN	$150 Copay IN; 25% Coinsurance OON
Preventive/Screening	$0 Copay IN	$0 Copay IN; 30% Coinsurance OON
Outpatient Physical and Speech Therapy	$15 Copay IN	$15 Copay IN; 25% Coinsurance OON
Medicare Covered Acupuncture	$26 Copay IN	$22 Copay IN; 25% Coinsurance OON
Outpatient Occupational Therapy	$15 Copay IN	$15 Copay IN; 25% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$40 Copay IN	$40 Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse and Opioid Treatment Services	$40 Copay IN	$40 Copay IN; 50% Coinsurance OON
Outpatient Surgical	ASC: $200 Copay IN Facility: $300 Copay IN	ASC: $175 Copay IN; 25% Coinsurance OON Facility: $275 Copay IN; 25% Coinsurance OON
Ambulance	$200 Copay	$315 Copay
Transportation	Not Covered	
Emergency Room	$130 Copay	
Urgent Care	$50 Copay	
Inpatient Hospital Stay	$225 per day for days 1 – 7, $1,575 OOP Max per year	INN: $205 per day for days 1 – 7, $1,435 OOP Max per year; OON: 30% Coinsurance
Inpatient Psychiatry Stay	$260 per day for days 1 – 6, $1,560 OOP Max per year	INN: $270 per day for days 1 – 6, $1,620 OOP Max per year; OON: 30% Coinsurance
Skilled Nursing Facility	$0 per day for days 1 – 20; $218 per day for days 21 – 100. No yearly benefit period maximum.	INN: $0 per day for days 1 – 20; $218 per day for days 21 – 100, No yearly benefit period maximum. OON: 30% Coinsurance
Home Health	$0 Copay IN	$0 Copay IN; 25% 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 Abbott® and Trividia. 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 Copay IN Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to Abbott® and Trividia. 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	INN: $0 compression stockings, diabetic shoes/inserts; 20% all other items OON: 50% Coinsurance
Healing at Home	Not Covered	
OTC Catalog	$60 quarterly allowance	$40 quarterly allowance
Meal Benefit	$0 copay, 1 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.	
Fitness Benefit	Covered in Full	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON
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	0% – 19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a $35 copay for a one month supply of 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)	$26 (except $0 for diabetic retinal eye exam)	$22 (except $0 for diabetic retinal eye exam); 25% coinsurance OON
Routine Vision (Office Visit)	$25 Copay IN; Benefit is carved out to Davis Vision; (One every year)	$25 Copay IN; 20% coinsurance OON; 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 and OON Combined; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	$26 Copay IN	$22 Copay IN; 25% Coinsurance OON
Routine Hearing Exam	$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 Visit: $0 Copay IN (2 every year) Includes exam and cleaning X-ray: $0 Copay IN (One every year)	Office Visit: $0 Copay IN; $0 Copay OON (2 every year) Includes exam, and cleaning X-ray: $0 Copay IN (One every year); $0 Copay OON
Medicare Covered Comprehensive Dental	$26 Copay IN	$22 Copay IN; 25% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Comprehensive maximum allowance of $2,000	
Comprehensive Dental — Supplemental	Restorative, Endodontics, Prosthodontics (removable and fixed), 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 covered IN. See EOC for benefit limits.	Restorative, Endodontics, Prosthodontics (removable and fixed), 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 covered IN and OON. See EOC for benefit limits.
Medicare Covered Chiropractic	$15 Copay IN	$15 Copay IN; 25% Coinsurance OON
Routine Chiropractic	$15 Copay IN (12 per plan year)	$15 Copay IN; 25% Coinsurance OON (12 per plan year)
Medicare Covered Podiatry	$26 Copay IN	$22 Copay IN; 25% Coinsurance OON
Routine Podiatry	$26 Copay IN (three visits)	$22 Copay IN; 25% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET: $10 Copay IN Partial Hospital/Intensive Outpatient Program Services: $55 copay IN Outpatient Blood: $0 copay IN	Cardiac and Pulmonary Rehab and SET: $15 Copay IN; 25% Coinsurance OON Partial Hospital/Intensive Outpatient Program Services: $55 copay IN; 25% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON
PART D DRUGS		
Formulary	Fundamental	
Deductible	Tier 1 – Tier 2: $0, Tier 3 – Tier 5: $615	
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: $1, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $3, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $7, Tier 2: $15, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $21, Tier 2: $45, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $7, Tier 3: 20%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $17.50, Tier 2: $37.50, Tier 3: 20%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	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, WNY (Products and pricing by county)

	WPA AND CPA/NEPA	WV	DE	SEPA	WNY
Monthly Plan Premium	$0			$0	
Part B Premium Giveback	$75		$70	$60	$50
Out-of-Pocket Maximum	Network: $6,000 OOP Max; Combined: $8,950 OOP Max		Network: $6,000 OOP Max; Combined: $8,950 OOP Max	Network: $6,000 OOP Max; Combined: $8,950 OOP Max	Network: $6,700 OOP Max; $10,000 OOP Max
PCP Office Visit	$0 Copay IN; 40% Coinsurance OON		$0 Copay IN; 40% Coinsurance OON	$0 Copay IN; 40% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Specialist Office Visit	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$35 Copay IN; 50% Coinsurance OON
Lab and Diagnostic Tests (Freestanding Lab)	$0 Copay IN; 40% Coinsurance OON		$0 Copay IN; 40% Coinsurance OON	$0 Copay IN; 40% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Outpatient Facility)	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 50% Coinsurance OON
X-rays	$20 Copay IN; 40% Coinsurance OON		$20 Copay IN; 40% Coinsurance OON	$20 Copay IN; 40% Coinsurance OON	$45 Copay IN; 50% Coinsurance OON
Radiation Therapy	$60 Copay IN; 40% Coinsurance OON		$60 Copay IN; 40% Coinsurance OON	$60 Copay IN; 40% Coinsurance OON	20% Coinsurance IN; 50% Coinsurance OON
Advanced Imaging	$225 Copay IN; 40% Coinsurance OON		$225 Copay IN; 40% Coinsurance OON	$225 Copay IN; 40% Coinsurance OON	$150 Copay IN; 50% Coinsurance OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/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
Outpatient Physical and Speech Therapy	$15 Copay IN; 40% Coinsurance OON		$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 50% Coinsurance OON
Medicare Covered Acupuncture	$15 Copay IN; 40% Coinsurance OON		$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$35 Copay IN; 50% Coinsurance OON
Outpatient Occupational Therapy	$15 Copay IN; 40% Coinsurance OON		$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 50% Coinsurance OON
Outpatient Mental Health and Psychiatric Therapy	$5 Copay IN; 40% Coinsurance OON		$5 Copay IN; 40% Coinsurance OON	$5 Copay IN; 40% Coinsurance OON	$5 Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse and Opioid Treatment Services	$5 Copay IN; 40% Coinsurance OON		$5 Copay IN; 40% Coinsurance OON	$5 Copay IN; 40% Coinsurance OON	$5 Copay IN; 50% Coinsurance OON
Outpatient Surgical	ASC: $195 Copay IN; $350 Copay OON Facility: $245 Copay IN; $375 Copay OON	ASC: $200 Copay IN; $350 Copay OON Facility: $250 Copay IN; $375 Copay OON	ASC: $195 Copay IN; $350 Copay OON Facility: $245 Copay IN; $375 Copay OON	ASC: $200 Copay IN; $375 Copay OON Facility: $250 Copay IN; $375 Copay OON	ASC: $225 Copay IN; 50% Coinsurance OON Facility: $325 Copay IN; 50% Coinsurance OON
Ambulance	Emergent/Non-Emergent: WPA: $330 Copay IN; CPA/NEPA: $275 Copay IN Non-Emergent: WPA: 30% Coinsurance OON; CPA/NEPA: 30% Coinsurance OON	Emergent/Non-Emergent: $425 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $425 IN; Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: $310 Copay IN; Non-Emergent: 30% Coinsurance OON	$385 Copay
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.		Not Covered	$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.	Not Covered
Emergency Room	$130 Copay		$130 Copay		
Urgent Care	$40 Copay	$50 Copay	$40 Copay		
Inpatient Hospital Stay	$275/admit IN; $395/admit OON		$275/admit IN; $395/admit OON	$300/admit IN; $395/admit OON	$290/day (days 1 – 7), $0/day (days 8 – 90) IN; 50% Coinsurance 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	$325/day (days 1 – 3), $0/day (days 4 – 90) IN; $475/day (days 1 – 3), $0/day (days 4 – 90) OON	$260 per day for days 1 – 6, $1,560 OOP Max per year IN; 50% Coinsurance OON
Skilled Nursing Facility	$0/day (days 1 – 20); $218/day (days 21 – 100) IN; 30% Coinsurance OON		$0/day (days 1 – 20); $218/day (days 21 – 100) IN; 30% Coinsurance OON	$0/day (days 1 – 20); $218/day (days 21 – 100) IN; 30% Coinsurance OON	$0/day (days 1 – 20); $218/day (days 21 – 100), No yearly benefit period maximum IN; 50% Coinsurance OON
Home Health	$0 Copay IN; 30% Coinsurance OON		$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 30% Coinsurance OON	$0 Copay IN; 50% Coinsurance OON
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and Trividia, 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; 40% Coinsurance OON		0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and Trividia, 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; 40% Coinsurance OON	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and Trividia, 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; 40% Coinsurance OON	$0 Copay IN Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to Abbott and Trividia. 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.). 40% Coinsurance OON
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN; 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON		
Healing at Home	Not Covered		Not Covered		
OTC Catalog	$100 Allowance Once Per Quarter		$100 Allowance Once Per Quarter	$100 Allowance Once Per Quarter	$40 quarterly allowance
Meal Benefit	Not Covered		Not Covered	Not Covered	$0 for 1 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.
Fitness Benefit	Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		Covered in Full IN; 50% Coinsurance after satisfying a $500 Deductible OON		
Additional Telehealth Services	Services covered with applicable cost share listed for in-person 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	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
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		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; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$35; (except $0 for diabetic retinal eye exam); 50% Coinsurance OON
Routine Vision (Office Visit)	$0 Copay IN; $50 Copay OON (One every year)		$0 Copay IN; $50 Copay OON (One every year)	$0 Copay IN; $50 Copay OON (One every year)	$0 Copay IN; 20% Coinsurance 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.		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.	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 IN and OON Combined; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$35 Copay IN; 50% Coinsurance OON
Routine Hearing Exam	$0 Copay IN; $0 Copay OON (One every year)		$0 Copay IN; $0 Copay OON (One every year)	$0 Copay IN; $0 Copay OON (One every year)	$0 Copay IN (One every year); $45 Copay OON
Routine Hearing (Hearing Aids)	Two Hearing Aids Every year; TruHearing Advanced — $699 copay; TruHearing Premium — $999 copay IN; $500 allowance IN/OON for any other hearing aid		Two Hearing Aids Every year; TruHearing Advanced — $699 copay; TruHearing Premium — $999 copay IN; $500 allowance IN/OON for any other hearing aid	Two Hearing Aids Every year; TruHearing Advanced — $699 copay; TruHearing Premium — $999 copay IN; $500 allowance IN/OON for any other hearing aid	Two Hearing Aids Every year; TruHearing Advanced — $699 copay; TruHearing Premium — $999 copay
Routine Dental	Office Visit: $0 Copay IN; 30% Coinsurance OON (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)		Office Visit: $0 Copay IN; 30% Coinsurance OON (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)	Office Visit: $0 Copay IN; 30% Coinsurance OON (Two every year) Includes exam, cleaning, and fluoride treatment X-ray: $0 Copay IN; 30% Coinsurance OON (One every year)	Office Visit: $0 Copay IN; $0 Copay OON (Two every year) Includes exam, cleaning and fluoride treatment X-ray: $0 Copay IN; $0 Copay OON (One every year)
Medicare Covered Comprehensive Dental	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$35 Copay IN; 50% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of $3,000	Combined maximum allowance of $2,000	Combined maximum allowance of $3,000	Combined maximum allowance of $3,000	Combined maximum allowance of $2,000
Comprehensive Dental — Supplemental	$0 Copay: Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, and Adjunctive General Services ($0 Palliative). 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and/or fixed), Oral/Maxillofacial Surgery, Adjunctive General Services: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endodontics, Periodontics, Prosthodontics, Oral/Maxillofacial Surgery: 40% Coinsurance IN/OON. Adjunctive General Services: 0% Palliative-40% All Others IN 40% 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 ($0 Palliative). 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endodontics, Periodontics, Prosthodontics (removable and fixed), Oral/Maxillofacial Surgery: 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.
Medicare Covered Chiropractic	$15 Copay IN; 40% Coinsurance OON		$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 40% Coinsurance OON	$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic	$15 Copay IN; 40% Coinsurance OON (Eight visits)		$15 Copay IN; 40% Coinsurance OON (Eight visits)	$15 Copay IN; 40% Coinsurance OON (Eight visits)	$15 Copay IN; 50% Coinsurance OON (six per plan year)
Medicare Covered Podiatry	$10 Copay IN; 40% Coinsurance OON		$10 Copay IN; 40% Coinsurance OON	$10 Copay IN; 40% Coinsurance OON	$35 Copay IN; 50% Coinsurance OON
Routine Podiatry	$10 Copay IN; 40% Coinsurance OON (10 visits)		$10 Copay IN; 40% Coinsurance OON (10 visits)	$10 Copay IN; 40% Coinsurance OON (10 visits)	$35 Copay IN; 50% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services, Outpatient Blood	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON		Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON	Cardiac and Pulmonary Rehab and SET, Partial Hospital/Intensive Outpatient Program Services: $0 Copay IN; 40% Coinsurance OON Outpatient Blood: $0 Copay IN; 30% Coinsurance OON	Cardiac and Pulmonary Rehab and SET: $15 Copay IN; 50% Coinsurance OON Partial Hospital/Intensive Outpatient Program Services: $55 Copay IN; 50% Coinsurance OON Outpatient Blood: $0 Copay IN; 50% Coinsurance OON
PART D DRUGS					
Formulary	Not Covered		Not Covered		
Deductible	Not Covered		Not Covered		
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.	Not Covered		Not Covered		
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Not Covered		Not Covered		
OOP Threshold	Not Covered		Not Covered		
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages. Excludes Deductible.	Not Covered		Not Covered		

Valor Product Highlights

$0 MA PPO plan without Part D provides national access to the BlueCard® Program, allowing veterans the flexibility to use for second opinions or to supplement Tricare/VA coverage. Includes Part B Giveback and rich Dental and mental health benefits.

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 Copay PCP IN
- $5 Copay Mental Health IN
- $10 Copay Specialist IN
- Up to $3,000 Dental allowance with no IN coinsurance in most regions
- $100 per quarter OTC allowance

Freedom PPO Valor

WNY

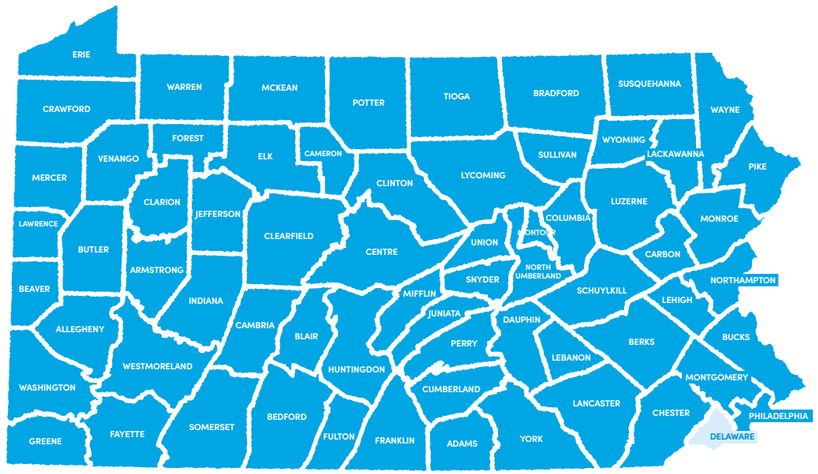
Part B giveback	
WNY	$50

Plan benefits also include:

- $0 Copay PCP IN
- $5 Copay Mental Health IN
- $2,000 Dental allowance
- $40 per quarter OTC allowance

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

Blue Rx PDP — PA, WV



Blue Rx

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

	PLUS	COMPLETE
Monthly Plan Premium	$193.20	$164.80
Formulary	Venture	Venture
Deductible	Tiers 1 – Tiers 5: $615	Tier 1 – Tier 2: $0; Tier 3 – Tier 5: $200
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.	Standard Retail: Tier 1: 25%, Tier 2: 25%, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%	Preferred Retail: Tier 1: $0, Tier 2: $5, Tier 3: 25%, Tier 4: 25%, Tier 5: 25% Standard Retail: Tier 1: $4, Tier 2: $10, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%
Initial Coverage. Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-day supply)	Standard Mail: Tier 1: 25%, Tier 2: 25%, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%	Preferred Mail: Tier 1: $0, Tier 2: $12.50, Tier 3: 25%, Tier 4: 25%, Tier 5: 25% Standard Mail: Tier 1: $10, Tier 2: $25, Tier 3: 25%, Tier 4: 25%, Tier 5: 25%
OOP Threshold	$2,100. 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. Excludes Deductible.	Tier 3 and Tier 4 Insulins: $35 for 31-day supply and $105 for 90-day supply at a retail or mail order pharmacy	

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**.

- **Highmark House Call:** Once a year, a licensed medical clinician will come to your client's home to review their medications, answer health-related questions, and make sure their medical history is up to date.
- **Blue Neighbors:** This volunteer program provides social support to our Highmark members. Blue Neighbors fosters friendships with volunteers who provide friendly phone calls or visits. Community clubs are also supported to foster connection. Book sets are provided for book clubs, incentives and marked courses for walking clubs, and supplies and meaningful donation opportunities for knitting/quilting clubs. Monthly dial-in programs, like learning lectures and bingo, can be accessed by seniors from home. To find out more about this program, please call **800-988-0706** or visit **highmark.com/plans/medicare/blue-neighbors**.
- **SilverSneakers:** Members can stay active and social with the Highmark Fitness Benefit, now including access to the SilverSneakers® Fitness program. With SilverSneakers members can take classes and use exercise equipment and other amenities, at no additional cost at thousands of participating locations. Enroll in as many locations as you like, at any time. Members also have access to a large variety of virtual classes taught by instructors who specialize in older adult fitness with SilverSneakers LIVE. Get started today by visiting **silversneakers.com** or calling **1-888-423-4632** (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.
- **Personalized Wellness Plan and Rewards:** All Medicare Advantage members gain access to a Personalized Wellness Plan and a Wellness Rewards program. Here's what your clients can expect:
  - Personalized Wellness Plan: Throughout the year, your clients will receive a customized checklist of preventive tests, screenings, and healthy activities tailored to their individual needs. The plan can be used to discuss their health goals with their doctor to determine screening options that are right for them.
  - Wellness Rewards: Your clients can earn a Highmark Wellness Reward for completing rewardable activities identified on their Personalized Wellness Plan. Highmark will send details to your client in their Personal Wellness Guide at the beginning of the year.

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 care plan and get recommended resources for 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, 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.
- Prescriptions, if needed, will be sent to the member's pharmacy of choice for pickup.

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.

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

Medicare Advantage Pharmacy Network

	Preferred Network (Preferred Copay)	Standard Network
PA	Costco Wholesale, CVS pharmacy, Giant, giant eagle, Kroger, Target, Walmart, weis	Walgreens
WV	Costco Wholesale, CVS pharmacy, Giant, giant eagle, Kroger, Target, Walmart, weis	Walgreens
DE	Costco Wholesale, Kroger, Walgreens, Walmart	CVS pharmacy, Target
NY	Costco Wholesale, Hannaford, Price Chopper, Walgreens, Walmart, Wegmans	CVS pharmacy, Target

Out of Network

- Select specialty pharmacies
- Select independent pharmacies

Changes to our pharmacy network may occur during the benefit year. An updated Pharmacy Directory is located on our website at **medicare.highmark.com**. *You may also call Customer Service at* ***1-800-290-3914*** *(TTY/TDD users should call 711) for updated information.*

Medicare Advantage In-Network Hospitals

WPA (pending CMS approval)

Freedom Blue PPO, Security Blue HMO-POS, Complete Blue PPO, Together Blue Medicare HMO, and Community Blue Medicare HMO In-Network Hospitals

Facility Name	Freedom Blue PPO	Security Blue HMO-POS	Complete Blue PPO and HMO	Together Blue Medicare HMO	Community Blue Medicare HMO
Allegheny County					
AHN Allegheny General Hospital	✓	✓	✓	✓	✓
AHN Allegheny Valley Hospital	✓	✓	✓	✓	✓
AHN Brentwood Neighborhood Hospital	✓	✓	✓	✓	✓
AHN Forbes Hospital	✓	✓	✓	✓	✓
AHN Harmar Neighborhood Hospital	✓	✓	✓	✓	✓
AHN Jefferson Hospital	✓	✓	✓	✓	✓
AHN McCandless Neighborhood Hospital	✓	✓	✓	✓	✓
AHN West Penn Hospital	✓	✓	✓	✓	✓
AHN Wexford Hospital	✓	✓	✓	✓	✓
Heritage Valley Sewickley	✓	✓	✓		✓
St. Clair Memorial Hospital	✓	✓	✓		✓
UPMC East	✓	✓	✓		
UPMC Magee	✓	✓	✓		
UPMC McKeesport	✓	✓	✓		
UPMC Mercy	✓	✓	✓		
UPMC Passavant	✓	✓	✓		
UPMC Presbyterian	✓	✓	✓		
UPMC Shadyside	✓	✓	✓		
UPMC St. Margaret's	✓	✓	✓		
Armstrong County					
Armstrong County Memorial Hospital	✓	✓	✓		✓
Beaver County					
Heritage Valley Beaver	✓	✓	✓		✓
Bedford County					
UPMC Bedford Memorial	✓	✓	✓	✓	✓
Blair County					
Conemaugh Nason Medical Center	✓	✓	✓		✓
Penn Highlands Tyrone	✓	✓	✓		✓
UPMC Altoona	✓	✓	✓	✓	✓
Butler County					
Butler Memorial Health System	✓	✓	✓		✓
UPMC Passavant — Cranberry	✓	✓	✓		✓
Cambria County					
Conemaugh Memorial Medical Center	✓	✓	✓		✓
Conemaugh Miners Medical Center	✓	✓	✓		✓
Clarion County					
Clarion Hospital	✓	✓	✓		✓
Clarion Psychiatric Center	✓	✓	✓	✓	✓

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Medicare Advantage In-Network Hospitals

WPA, cont. (pending CMS approval)

Freedom Blue PPO, Security Blue HMO-POS, Complete Blue PPO, Together Blue Medicare HMO, and Community Blue Medicare HMO In-Network Hospitals

Facility Name	Freedom Blue PPO	Security Blue HMO-POS	Complete Blue PPO and HMO	Together Blue Medicare HMO	Community Blue Medicare HMO
Clearfield County					
Penn Highlands Clearfield	✓	✓	✓		✓
Penn Highlands DuBois	✓	✓	✓		✓
Crawford County					
Meadville Medical Center	✓	✓	✓		✓
Titusville Area Hospital	✓	✓	✓		✓
Elk County					
Penn Highlands Elk	✓	✓	✓		✓
Erie County					
AHN Saint Vincent Hospital	✓	✓	✓	✓	✓
LECOM Health — Corry Memorial Hospital	✓	✓	✓		✓
LECOM Health — Millcreek Community Hospital	✓	✓	✓		✓
UPMC Hamot	✓	✓	✓		
Fayette County					
Penn Highlands Connellsville	✓	✓	✓		✓
Greene County					
UPMC Greene	✓	✓	✓		✓
Huntingdon County					
Penn Highlands Huntingdon Hospital	✓	✓	✓		✓
Indiana County					
Indiana Regional Medical Center	✓	✓	✓		✓
Jefferson County					
Penn Highlands Brookville	✓	✓	✓		✓
Punxsutawny Area Hospital	✓	✓	✓		✓
Lawrence County					
UPMC Jameson	✓	✓	✓	✓	✓
McKean County					
Bradford Regional Medical Center	✓	✓	✓		✓
UPMC Kane	✓	✓	✓	✓	✓
Mercer County					
AHN Grove City	✓	✓	✓	✓	✓
Edgewood Surgical Hospital	✓	✓	✓		✓
Sharon Regional Medical Center	✓	✓	✓		✓
UPMC Horizon	✓	✓	✓	✓	✓
UPMC Horizon — Shenango Campus	✓	✓	✓	✓	✓
Potter County					
UPMC Cole	✓	✓	✓	✓	✓

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Medicare Advantage In-Network Hospitals

WPA, cont. (pending CMS approval)

Freedom Blue PPO, Security Blue HMO-POS, Complete Blue PPO, Together Blue Medicare HMO, and Community Blue Medicare HMO In-Network Hospitals

Facility Name	Freedom Blue PPO	Security Blue HMO-POS	Complete Blue PPO and HMO	Together Blue Medicare HMO	Community Blue Medicare HMO
Somerset County					
Chan Soon-Shiong Medical Center at Windber	✓	✓	✓		✓
Conemaugh Meyersdale Medical Center	✓	✓	✓		✓
UPMC Somerset	✓	✓	✓	✓	✓
Venango County					
UPMC Northwest	✓	✓	✓	✓	✓
Warren County					
Warren General Hospital	✓	✓	✓		✓
Washington County					
Advanced Surgical Hospital	✓	✓	✓		✓
AHN Canonsburg Hospital	✓	✓	✓	✓	✓
Penn Highlands Mon Valley Hospital	✓	✓	✓		✓
UPMC Washington	✓	✓	✓		✓
Westmoreland County					
AHN Hempfield Neighborhood Hospital	✓	✓	✓	✓	✓
Excela Health Frick Hospital	✓	✓	✓		✓
Excela Health Latrobe Hospital	✓	✓	✓		✓
Excela Health Westmoreland Hospital	✓	✓	✓		✓

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Medicare Advantage In-Network Hospitals

CPA and NEPA (pending CMS approval)

Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare Plus PPO, and Community Blue Medicare PPO In-Network Hospitals

Facility Name	Freedom Blue PPO	Community Blue Medicare HMO	Community Blue Medicare Plus PPO/ Complete Blue Plus PPO	Community Blue Medicare PPO/ Complete Blue PPO
Adams County				
WellSpan Gettysburg Hospital	✓	✓	✓	✓
Berks County				
Penn State Health St. Joseph Medical Center	✓	✓	✓	✓
Reading Hospital	✓		✓	✓
Surgical Institute of Reading	✓		✓	✓
Bradford County				
Guthrie Robert Packer Hospital	✓	✓	✓	✓
Guthrie Robert Packer Hospital — Towanda Campus	✓	✓	✓	✓
Guthrie Troy Community Hospital	✓	✓	✓	✓
Carbon County				
Lehigh Valley Hospital — Carbon	✓	✓	✓	✓
St. Luke's Hospital — Carbon	✓		✓	✓
St. Luke's Hospital — Lehighton Campus	✓		✓	✓
Centre County				
Mount Nittany Medical Center	✓	✓	✓	✓
Clinton County				
UPMC Lock Haven	✓		✓	✓
Columbia County				
Geisinger Bloomsburg Hospital	✓		✓	✓
Cumberland County				
Penn State Health Hampden Medical Center	✓	✓	✓	✓
Penn State Health Holy Spirit Hospital	✓	✓	✓	✓
UPMC Carlisle	✓		✓	✓
UPMC West Shore	✓	✓	✓	✓
Dauphin County				
Penn State Health Milton S. Hershey Medical Center	✓	✓	✓	✓
UPMC Community Osteopathic	✓	✓	✓	✓
UPMC Harrisburg Campus	✓	✓	✓	✓
Franklin County				
WellSpan Chambersburg Hospital	✓	✓	✓	✓
WellSpan Waynesboro Hospital	✓	✓	✓	✓
Fulton County				
Fulton County Medical Center	✓	✓	✓	✓

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Medicare Advantage In-Network Hospitals

CPA and NEPA, cont. (pending CMS approval)

Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare Plus PPO, and Community Blue Medicare PPO In-Network Hospitals

Facility Name	Freedom Blue PPO	Community Blue Medicare HMO	Community Blue Medicare Plus PPO/ Complete Blue Plus PPO	Community Blue Medicare PPO/ Complete Blue PPO
Lackawanna County				
Geisinger Community Medical Center	✓		✓	✓
Lehigh Valley Hospital — Dickson City	✓	✓	✓	✓
Moses Taylor Hospital	✓	✓	✓	✓
Regional Hospital of Scranton	✓	✓	✓	✓
Lancaster County				
Lancaster General Hospital	✓	✓	✓	✓
Penn State Health Lancaster Medical Center	✓	✓	✓	✓
UPMC Lititz	✓		✓	✓
WellSpan Ephrata Community Hospital	✓	✓	✓	✓
Lebanon County				
WellSpan Good Samaritan Hospital	✓	✓	✓	✓
Lehigh County				
Lehigh Valley Hospital — 17th Street	✓	✓	✓	✓
Lehigh Valley Hospital — Cedar Crest	✓	✓	✓	✓
Lehigh Valley Hospital — Macungie	✓	✓	✓	✓
St. Luke's Hospital Allentown	✓		✓	✓
St. Luke's Sacred Heart Hospital	✓		✓	✓
Luzerne County				
Lehigh Valley Hospital — Hazleton	✓	✓	✓	✓
Wilkes-Barre General Hospital	✓	✓	✓	✓
Lycoming County				
Geisinger Jersey Shore Hospital	✓		✓	✓
Geisinger Medical Center Muncy	✓		✓	✓
UPMC Muncy	✓	✓	✓	✓
UPMC Williamsport Divine Providence Hospital	✓	✓	✓	✓
UPMC Williamsport Hospital	✓	✓	✓	✓
Mifflin County				
Geisinger Lewistown Hospital	✓		✓	✓
Montour County				
Geisinger Medical Center			✓	
Monroe County				
Lehigh Valley Hospital — Pocono	✓	✓	✓	✓
St. Luke's Hospital — Monroe Campus	✓		✓	✓

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Medicare Advantage In-Network Hospitals

CPA and NEPA, cont. (pending CMS approval)

Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare Plus PPO, and Community Blue Medicare PPO In-Network Hospitals

Facility Name	Freedom Blue PPO	Community Blue Medicare HMO	Community Blue Medicare Plus PPO/ Complete Blue Plus PPO	Community Blue Medicare PPO/ Complete Blue PPO
Northampton County				
Lehigh Valley Hosptial — Hecktown Oaks	✓	✓	✓	✓
Lehigh Valley Hospital — Muhlenberg	✓	✓	✓	✓
St. Luke's Hospital — Anderson	✓		✓	✓
St. Luke's Hospital — Bethlehem	✓		✓	✓
St. Luke's Hospital — Easton	✓		✓	✓
Northumberland County				
Geisinger Shamokin Area Community Hospital	✓		✓	✓
Schuylkill County				
Geisinger St. Luke's Hospital	✓		✓	✓
Lehigh Valley Hospital — Schuylkill East Norwegian Street	✓	✓	✓	✓
Lehigh Valley Hospital — Schuylkill South Jackson Street	✓	✓	✓	✓
St. Luke's Miners Memorial Hospital	✓		✓	✓
Susquehanna County				
Barnes-Kasson County Hospital	✓	✓	✓	✓
Endless Mountain Health Systems	✓	✓	✓	✓
Tioga County				
UPMC Wellsboro	✓	✓	✓	✓
Union County				
Evangelical Community Hospital	✓	✓	✓	✓
Wayne County				
Wayne Memorial Hospital	✓	✓	✓	✓
Wyoming County				
Tyler Memorial Hospital	✓	✓	✓	✓
York County				
OSS Health Orthopaedic Hospital	✓		✓	✓
UPMC Hanover	✓		✓	✓
UPMC Memorial	✓		✓	✓
WellSpan Surgery and Rehabilitation Hospital	✓	✓	✓	✓
WellSpan York Hospital	✓	✓	✓	✓

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Medicare Advantage In-Network Hospitals

SEPA (pending CMS approval)

Freedom Blue PPO and Complete Blue PPO In-Network Hospitals

Facility Name	Freedom Blue PPO	Complete Blue PPO
Bucks County		
Doylestown Hospital	✓	✓
Grand View Hospital	✓	✓
Jefferson Health — Bucks Hospital	✓	✓
Prime Healthcare — Lower Bucks Hospital	✓	✓
St. Luke's Hospital — Quakertown Campus	✓	✓
St. Luke's Hospital — Upper Blucks Campus	✓	✓
Trinity Health — St. Mary Medical Center	✓	✓
Chester County		
Penn Medicine — Chester County Hospital	✓	✓
Tower Health — Phoenixville Hospital	✓	✓
Delaware County		
Trinity Health — Mercy Fitzgerald Hospital	✓	✓
Montgomery County		
Einstein Medical Center Elkins Park	✓	✓
Einstein Medical Center Montgomery	✓	✓
Holy Redeemer Hospital	✓	✓
Jefferson Health — Abington Hospital	✓	✓
Jefferson Health — Abington-Lansdale Hospital	✓	✓
Lehigh Valley Gilbertsville	✓	✓
Prime Healthcare — Suburban Community Hospital	✓	✓
Tower Health — Pottstown Hospital	✓	✓
Philadelphia County		
Jefferson Health — Frankford Hospital	✓	✓
Jefferson Health — Jefferson Einstein Hospital	✓	✓
Jefferson Health — Methodist Hospital	✓	✓
Jefferson Health — Thomas Jefferson University Hospital	✓	✓
Jefferson Health — Torresdale Hospital	✓	✓
Penn Medicine — Hospital of the University of Pennsylvania	✓	✓
Penn Medicine — Penn Presbyterian Medical Center	✓	✓
Penn Medicine — Pennsylvania Hospital	✓	✓
Prime Healthcare — Roxborough Memorial Hospital	✓	✓
Temple Health — Fox Chase Cancer Center	✓	✓
Temple Health — Temple University Hospital	✓	✓
Temple Health — Chestnut Hill Hospital	✓	✓
Trinity Health — Nazareth Hospital	✓	✓

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Medicare Advantage In-Network Hospitals

WV (pending CMS approval)

Complete Blue PPO and Freedom Blue PPO In-Network Hospitals

Facility Name	Complete Blue PPO and Freedom Blue PPO
	County
Broaddus Hospital	Barbour
WVU Medicine — Berkeley Medical Center	Berkeley
Boone Memorial Hospital	Boone
WVU Medicine — Braxton County Memorial Hospital	Braxton
Acuity Specialty Hospital of Ohio Valley — Weirton	Brooke
Weirton Medical Center	
Cabell Huntington Hospital	Cabell
River Park Hospital	
St. Mary's Medical Center	
Minnie Hamilton Health Center	Calhoun
Montgomery General Hospital	Fayette
CAMC — Plateau Medical Center	
WVU Medicine — Grant Memorial Hospital	Grant
CAMC — Greenbrier Valley Medical Center	Greenbrier
Valley Health — Hampshire Memorial Hospital	Hampshire
Highland — Clarksburg Hospital	Harrison
WVU Medicine — United Hospital Center	
WVU Medicine — Jackson General Hospital	Jackson
WVU Medicine — Jefferson Medical Center	Jefferson
CAMC — Charleston Surgical Hospital	Kanawha
Charleston Area Medical Center	
Select Specialty Hospital — Charleston	
WVU Medicine — Saint Francis Hospital	
WVU Medicine — Thomas Memorial Hospital	
Mon Health Stonewall Jackson Memorial Hospital	Lewis
Logan Regional Medical Center	Logan
Mon Health Marion Neighborhood Hospital	Marion
WVU Medicine — Fairmont Medical Center	

Facility Name	Complete Blue PPO and Freedom Blue PPO
	County
WVU Medicine — Reynolds Memorial Hospital	Marshall
Rivers Health	Mason
Welch Community Hospital	McDowell
WVU Medicine — Princeton Community Hospital	Mercer
WVU Medicine — Potomac Valley Hospital	Mineral
Mon Health Medical Center	Monongalia
WVU Medicine — Chestnut Ridge Center	
WVU Medicine — Children's Hospital	
WVU Medicine — J.W. Ruby Memorial Hospital	
Valley Health — War Memorial Hospital	Morgan
WVU Medicine — Summersville Regional Medical Center	Nicholas
Acuity Specialty Hospital of Ohio Valley — Wheeling	Ohio
WVU Medicine — Wheeling Hospital	
Pocahontas Memorial Hospital	Pocahontas
Mon Health Preston Memorial Hospital	Preston
CAMC — Teays Valley Hospital	Putnam
Beckley ARH Hospital	Raleigh
Raleigh General Hospital	
Davis Medical Center	Randolph
Roane General Hospital	Roane
Summers County ARH Hospital	Summers
Mon Health Grafton City Hospital	Taylor
Sistersville General Hospital	Tyler
WVU Medicine — St. Joseph's Hospital	Upshur
Webster County Memorial Hospital	Webster
WVU Medicine — Wetzel County Hospital	Wetzel
WVU Medicine — Camden Clark Medical Center	Wood

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Medicare Advantage In-Network Hospitals

DE (pending CMS approval)

Complete Blue PPO In-Network Hospitals

Facility Name	Complete Blue PPO
	County
Bayhealth Hospital — Kent Campus	Kent
ChristianaCare — Christiana Hospital	New Castle
ChristianaCare — Wilmington Hospital	
Delaware Psychiatric Center	
Select Specialty Hospital — Wilmington	
St. Francis Hospital	
Bayhealth Hospital — Sussex Campus	Sussex
Beebe Medical Center	
TidalHealth — Nanticoke Hospital	

Medicare Advantage In-Network Hospitals

Northeastern New York (pending CMS approval)

In-Network Hospitals

Facility Name	County
Albany Medical Center Hospital	Albany
Albany Medical Center Hospital Rehab	
Albany Medical Center South Clinical Campus	
Samaritan Hospital — Albany Memorial Campus	
St. Peter's Hospital	
Columbia Memorial Hospital	Columbia
Alice Hyde Medical Center	Franklin
Nathan Littauer Hospital	Fulton
Little Falls Hospital	Herkimer
St. Mary's Healthcare	Montgomery
St. Mary's Hospital Memorial Campus	
Samaritan Hospital	Rensselaer
Saratoga Hospital	Saratoga
Bellevue Woman's Care Center of Ellis Hospital	Schenectady
Ellis Hospital	
Sunnyview Hospital	
Cobleskill Regional Hospital	Schoharie
HealthAlliance Mary's Avenue Campus	Ulster
Glens Falls Hospital	Warren

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Medicare Advantage In-Network Hospitals

Western New York (pending CMS approval)

Community Blue Medicare HMO, Senior Blue, Forever Blue 751 PPO, and Forever Blue Value PPO In-Network Hospitals

Facility Name	Community Blue Medicare HMO, Senior Blue, Forever Blue 751 PPO, and Forever Blue Value PPO
	County
Cuba Memorial Hospital	Allegany
Jones Memorial Hospital	
Brooks Memorial Hospital	Cattaraugus
Lakeshore Hospital	
Olean General Hospital	
UPMC Chautauqua	
Westfield Memorial Hospital	
Bertrand Chaffee Hospital	Erie (NY)
BryLin Hospital	
Buffalo General Hospital	
Erie County Medical Center	
John R. Oishei Children's Hospital	
Kaleida Heath	
Kenmore Mercy Hospital	
Mercy Hospital of Buffalo	
Millard Fillmore Suburban Hospital	
Roswell Park Comprehensive Cancer Center*	
Sisters of Charity Hospital	
Sisters of Charity Hospital — St. Joseph Campus	
AHN Saint Vincent Hospital	Erie (PA)
Encompass Health Rehabilitation Hospital of Erie	
UPMC Hamot	
United Memorial Medical Center	Genesee
Nicholas H. Noyes Memorial Hospital	Livingston
Bradford Regional Medical Center	McKean
Highland Hospital	Monroe
Rochester General Hospital	
Strong Memorial Hospital	
Unity Hospital of Rochester	
Unity Hospital of Rochester — Buffalo Road	
DeGraff Memorial Hospital	Niagara
Lockport Memorial Hospital	
Mount St. Mary's Hospital	
Niagara Falls Memorial Medical Center	
The Frederick Ferris Thompson Hospital	Ontario
Medina Memorial Hospital	Orleans
UPMC Cole	Potter
St. James Hospital	Steuben
Newark Wayne Community Hospital	Wayne
Wyoming County Community Hospital	Wyoming

** Out of network for Community Blue Medicare HMO*

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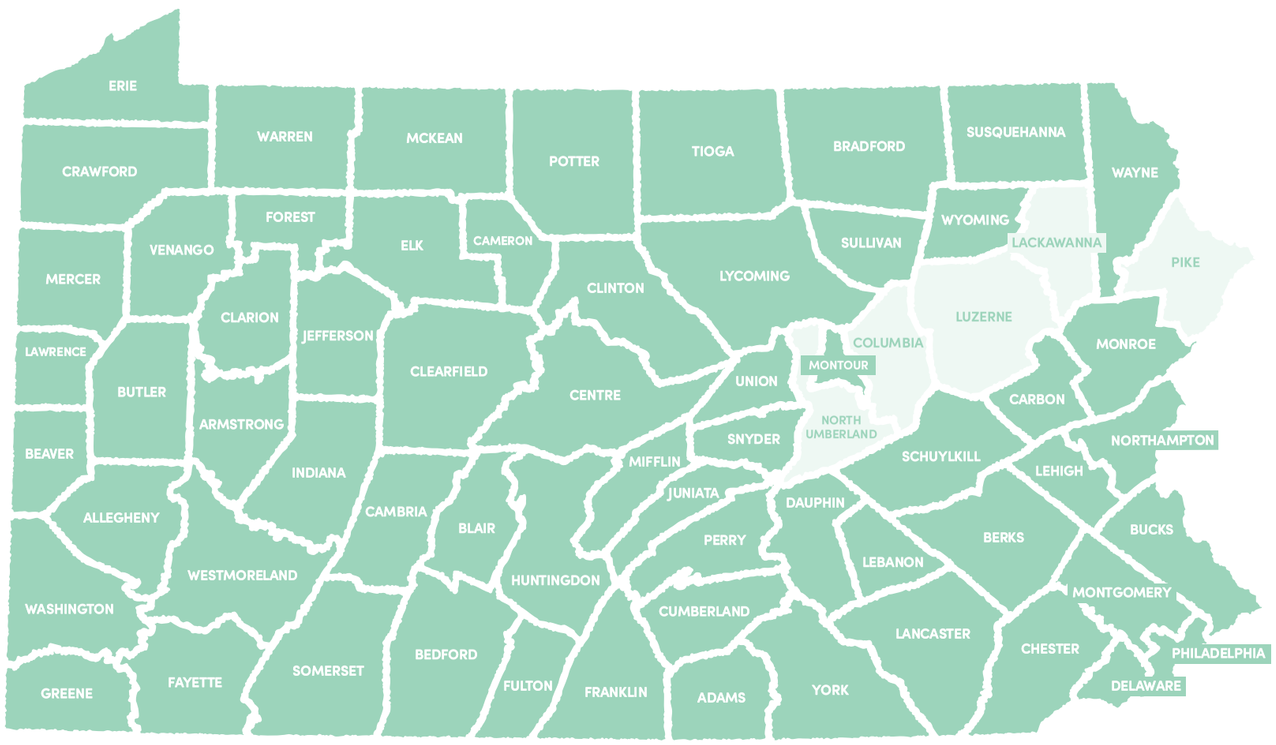
PRODUCTS AND PRICING BY COUNTY

D-SNP

Highmark Wholecare Medicare Assured Diamond and Ruby — PA



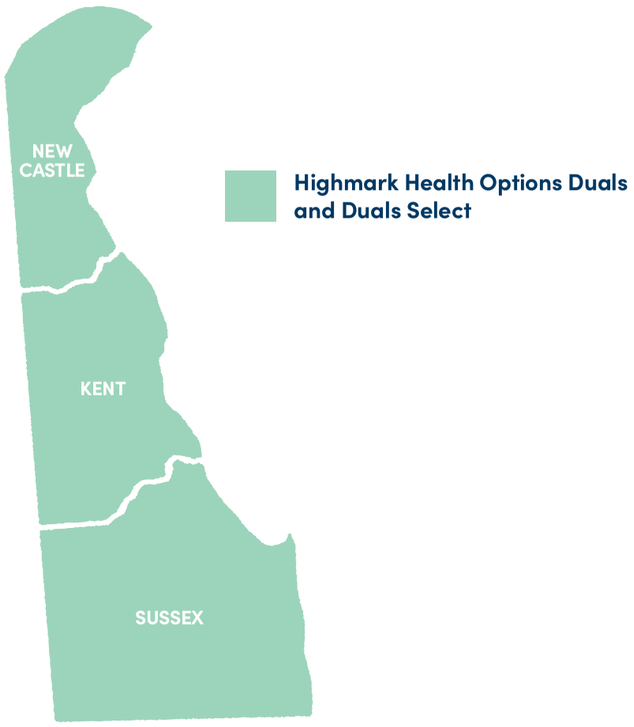
Highmark Wholecare Medicare Assured Diamond and Ruby

**Pricing is subject to CMS approval*

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

	HIGHMARK WHOLECARE MEDICARE ASSURED DIAMOND	HIGHMARK WHOLECARE MEDICARE ASSURED RUBY
Monthly Plan Premium	$0	$0
Out-of-Pocket Maximum	$9,250 OOP Max	$8,000 OOP Max
PCP Office Visit	$0 Copay	$0 Copay
Specialist Office Visit	$0 Copay	$30 Copay
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	$0 Copay and Authorization required	$5 Copay and Authorization required
Lab and Diagnostic Tests (Outpatient Facility)	$0 Copay and Authorization required	$5 Copay and Authorization required
X-rays	$0 Copay and Authorization required	$20 Copay and Authorization required
Radiation Services (Diagnostic and Therapeutic Radiological Services)	$0 Copay and Authorization required	10% Coinsurance for Diagnostic Radiological Services and Authorization required; $60 Copay for Therapeutic Radiological Services and Authorization required.
Medicare Covered Preventive Services	$0 Copay	$0 Copay
Outpatient Physical and Speech Therapy	$0 Copay and Authorization required	$0 Copay and Authorization required
Outpatient Mental Health	$0 Copay for Individual and Group Sessions	$10 Copay for Individual and Group Sessions
Outpatient Substance Abuse	$0 Copay for Individual and Group Sessions	$30 Copay for Individual and Group Sessions
Other Health Care Professional Services	$0 Copay; Medicare covered acupuncture is covered as part of other health care professional services. Prior Authorization only required only for acupuncture.	$30 Copay for Medicare covered acupuncture and Authorization required; $25 Copay for all other health care professional services.
Ambulatory Surgical Center (ASC)	$0 Copay and Authorization required	$225 Copay and Authorization required
Ambulance	$0 Copay for Ground and Air. Authorization required for Non-Emergency Medicare Services	$250 Copay for Ground and Air. Authorization required for Non-Emergency Medicare Services
Non-Emergency Medical Transportation	Twenty-four one-way health related trips only. Trip limit of sixty mile radius one-way. Extra mileage up to eighty 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 restrictions apply.	Not Covered. Members may use flex card dollars for pay-at-the-pump gas option.
Emergency Room	$0 Copay	$115 Copay will be waived if admitted to Hospital within twenty-four hours for the same condition.
Urgent Care	$0 Copay	$25 Copay
Inpatient Hospital Stay (Acute and Psychiatric)	$0 and Authorization required	$275 Copay days 1 – 6; $0 Copay days 7 – 90; Authorization required
Skilled Nursing Facility	$0 and Authorization required	$0 Copay days 1 – 20; CMS max days 21 – 100; Authorization required
Home Health	$0 and Authorization required	$0 Copay; Authorization required
Diabetic Supplies	$0 Copay	10% Coinsurance
SSBCI Flex Card and Non-SSBCI Flex Card	SSBCI Qualified Members receive $300 per month combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), and Pay-at-the-Pump gas (SSBCI). Members can use the $300 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply. Non-SSBCI Members receive $100 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the $100 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.	SSBCI Qualified Members receive $165 per quarter combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), and Pay-at-the-Pump gas (SSBCI). Members can use the $165 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply. Non-SSBCI Members receive $45 per quarter combined allowance for OTC and Home/Bathroom Safety. Members can use the $45 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply.
Durable Medical Equipment, Prosthetic Devices, Medical Supplies	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Meal Benefit	28 meals over 14 days, no limit for the number of admissions. Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply.	14 meals over 7 days, no limit for the number of admissions. Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply.
Fitness Benefit	The plan offers a fitness program membership beneficial for Medicare-eligible persons of all fitness levels. Members have access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. The program focuses on improving and maintaining strength, balance, and overall fitness.	The plan offers a fitness program membership beneficial for Medicare-eligible persons of all fitness levels. Members have access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. The program focuses on improving and maintaining strength, balance, and overall fitness.
Personal Emergency Response System (PERS)	Benefit coordinated through Highmark Wholecare Health Case Management Department. Limited to one PERS device per member per lifetime.	Benefit coordinated through Highmark Wholecare Health Case Management Department. Limited to one PERS device per member per lifetime.
Additional Telehealth Services	$0 copay	$0 Copay for PCP; $10 Copay for Mental Health and Psychiatric; $30 Copay for Specialist.
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 Eye Exam	$0 Copay	$0 Copay for diabetic retinal eye exam; $30 Copay applies to all other Medicare-covered benefits.
Medicare Covered Eyewear	$0 Copay	$0 Copay
Routine Eye Exam — Supplemental	$0 Copay; One visit per year	$0 Copay; One visit per year
Routine Eyewear — Supplemental	$600 per year allowance for eyeglass frames OR contact lenses. 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.	$150 per year allowance for eyeglass frames OR contact lenses. 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	$30 Copay
Routine Hearing Exams — Supplemental	$0 Copay; One visit per year	$0 Copay; One visit per year
Routine Hearing Aids — Supplemental	Two hearing aids every three years (one aid per ear). Must see a TruHearing provider.	Two hearing aids every three years (one aid per ear). Must see a TruHearing provider.
Medicare Dental Services	$0 Copay; Authorization may be required for Medicare covered services.	$30 Copay; Authorization may be required for Medicare covered services.
Comprehensive Dental — Supplemental	$6,500 every year; Amalgam or resin fillings unlimited; Crowns limited to two per year, one crown in five years per tooth; Two Endodontics Services per year; 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; Dentures are covered one per arch every year including a full denture, a partial denture or an immediate denture, and denture repairs; Simple extractions only.	$2,000 every year; Amalgam or resin fillings unlimited; Crowns limited to one per year, one crown in five years per tooth; One Endodontics Service per year; 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; 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; Simple extractions only.
Routine Dental — Supplemental	$6,500 every year (combined with Comprehensive); One oral exam every six months; Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months; Any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year.	$2,000 every year (combined with Comprehensive); One oral exam every six months; Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months; Any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year.
Medicare Covered Chiropractic	$0 Copay and Authorization required	$15 Copay and Authorization required
Routine Chiropractic	$0 Copay and Authorization required; Twelve visits per year	$15 Copay and Authorization required; Four visits per year
Medicare Covered Podiatry	$0 Copay	$25 Copay
Routine Podiatry	$0 Copay; Six visits per year	$25 Copay and Authorization required; Six visits per year
Cardiac, Intensive Cardiac, Pulmonary Rehab and SET	$0 Copay	$0 Copay
PART D DRUGS		
Part D Reduced Cost Sharing	Members will pay their LIS cost share for generic and brand name drugs covered under Highmark's formulary.	

Highmark Health Options Duals and Duals Select — DE

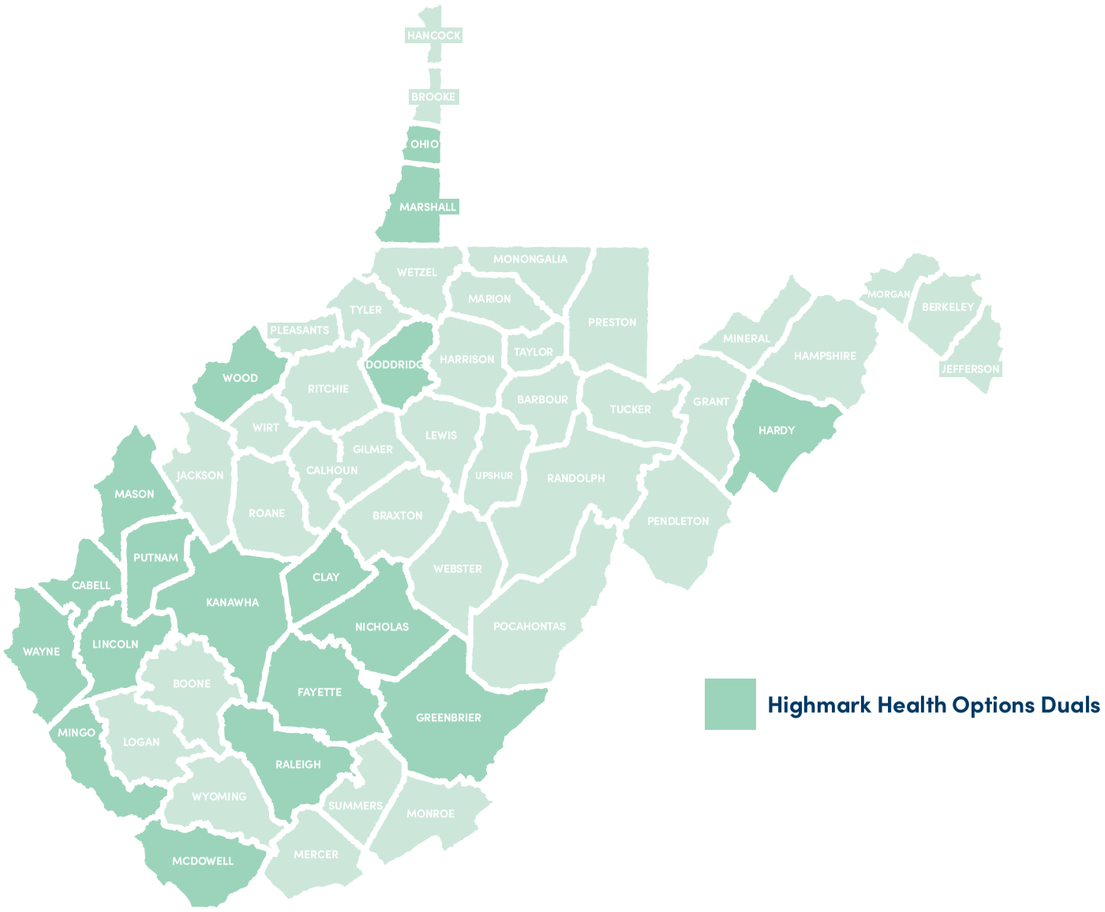


**Pricing is subject to CMS approval*

Highmark Health Options Duals and Duals Select — DE (Products and pricing by county)

	HIGHMARK HEALTH OPTIONS DUALS	NEW: HIGHMARK HEALTH OPTIONS DUALS SELECT
Monthly Plan Premium	$0	$0
Out-of-Pocket Maximum	$9,250 OOP Max	$9,250 OOP Max
PCP Office Visit	$0 Copay	20% Coinsurance
Specialist Office Visit	$0 Copay	20% Coinsurance
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Lab and Diagnostic Tests (Outpatient Facility)	$0 Copay and Authorization required	20% Coinsurance and Authorization required
X-rays	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Radiation Services (Diagnostic and Therapeutic Radiological Services)	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Medicare Covered Preventive Services	$0 Copay	20% Coinsurance
Outpatient Physical and Speech Therapy	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Outpatient Mental Health	$0 Copay for Individual and Group Sessions	20% Coinsurance for Individual and Group Sessions
Outpatient Substance Abuse	$0 Copay for Individual and Group Sessions	20% Coinsurance for Individual and Group Sessions
Other Health Care Professional Services	0% Coinsurance; Medicare covered acupuncture is covered as part of other health care professional services. Prior authorization only required only for acupuncture.	20% Coinsurance; Medicare covered acupuncture is covered as part of other health care professional services. Prior authorization only required only for acupuncture.
Ambulatory Surgical Center (ASC)	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Ambulance	0% Coinsurance for Ground and Air; Authorization required for Non-Emergency Medicare Services.	20% Coinsurance for Ground and Air; Authorization required for Non-Emergency Medicare Services.
Non-Emergency Medical Transportation	Not Covered. Members may use flex card dollars for pay-at-the-pump gas option or utilize their Medicaid transportation benefits by scheduling through their Care Manager.	Not Covered
Emergency Room	$0 Copay	$115 Copay
Urgent Care	$0 Copay	$40 Copay
Inpatient Hospital Stay (Acute and Psychiatric)	$0 and Authorization required	CMS max copay; Authorization required
Skilled Nursing Facility	$0 Copay and Authorization required	$0 Copay days 1 – 20; CMS max days 21 – 100; Authorization required
Home Health	$0 Copay and Authorization required	$0 Copay and Authorization required
Diabetic Supplies	$0 Copay	20% Coinsurance
SSBCI Flex Card and Non-SSBCI Flex Card	SSBCI Qualified Members receive $250 per month combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), and Pay-at-the-Pump gas (SSBCI). Members can use the $250 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply. Non-SSBCI Members receive $50 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the $50 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.	SSBCI Qualified Members receive $250 per quarter combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI)and Utility (SSBCI). Members can use the $250 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply. Non-SSBCI Members receive $50 per quarter combined allowance for OTC and Home/Bathroom Safety. Members can use the $50 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the quarter. Fees and plan restrictions apply.
Durable Medical Equipment, Prosthetic Devices, Medical Supplies	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Meal Benefit	Fourteen meals over seven days, no limit for the number of admissions. Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply.	Fourteen meals over seven days, no limit for the number of admissions. Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply.
Fitness Benefit	The plan offers a fitness program membership beneficial for Medicare-eligible persons of all fitness levels. Members have access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. The program focuses on improving and maintaining strength, balance, and overall fitness.	The plan offers a fitness program membership beneficial for Medicare-eligible persons of all fitness levels. Members have access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. The program focuses on improving and maintaining strength, balance, and overall fitness.
Personal Emergency Response System (PERS)	Not Covered	Not Covered
Additional Telehealth Services	$0 copay	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 Eye Exam	$0 Copay	20% Coinsurance
Medicare Covered Eyewear	$0 Copay	20% Coinsurance
Routine Eye Exam — Supplemental	$0 Copay; One visit per year	$0 Copay; One visit per year
Routine Eyewear — Supplemental	$400 allowance for eyeglass frames OR contact lenses per year. 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.	$150 allowance for eyeglass frames OR contact lenses per year. 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	20% Coinsurance
Routine Hearing Exams — Supplemental	$0 Copay; One visit per year	$0 Copay; One visit per year
Routine Hearing Aids — Supplemental	Two hearing aids every three years (one aid per ear). Must see a TruHearing provider.	Two hearing aids every three years (one aid per ear). Must see a TruHearing provider.
Medicare Dental Services	$0 Copay; Authorization may be required for Medicare covered services.	20% Coinsurance; Authorization may be required for Medicare covered services.
Comprehensive Dental — Supplemental	$3,000 every year; Amalgam or resin fillings unlimited. Crowns limited to two per year, one crown in five years per tooth; Two Endodontics Services per year; 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; Dentures are covered one per arch every year including a full denture, a partial denture or an immediate denture, and denture repairs; Simple extractions only.	$1,500 every year; Amalgam or resin fillings unlimited. Crowns limited to one per year, one crown in five years per tooth; One Endodontics Service per year; 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; 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; Simple extractions only.
Routine Dental — Supplemental	$3,000 every year (combined with Comprehensive); One oral exam every six months; Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months; Any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year.	$1,500 every year (combined with Comprehensive); One oral exam every six months; Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months; Any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year.
Medicare Covered Chiropractic	$0 Copay and Authorization required	20% Coinsurance and Authorization required
Routine Chiropractic	$0 Copay and Authorization required; Six visits per year	$15 Copay and Authorization required; Six visits per year
Medicare Covered Podiatry	$0 Copay	20% Coinsurance
Routine Podiatry	$0 Copay; 0% Coinsurance; Six visits per year	$25 Copay; Six visits per year
Cardiac, Intensive Cardiac, Pulmonary Rehab and SET	$0 Copay	20% Coinsurance
PART D DRUGS		
Part D Reduced Cost Sharing	Members will pay their LIS cost share for generic and brand name drugs covered under Highmark's formulary.	

New: Highmark Health Options Duals —WV



**Pricing is subject to CMS approval*

New: Highmark Health Options Duals —WV (Products and pricing by county)

	NEW: HIGHMARK HEALTH OPTIONS DUALS
Monthly Plan Premium	$0
Out-of-Pocket Maximum	$9,250 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 Services (Diagnostic and Therapeutic Radiological Services)	$0 Copay and Authorization required
Medicare Covered Preventive Services	$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 for Individual and Group Sessions
Other Health Care Professional Services	$0 Copay; Medicare covered acupuncture is covered as part of other health care professional services. Prior authorization only required only for acupuncture.
Ambulatory Surgical Center (ASC)	$0 Copay and Authorization required
Ambulance	$0 Copay for Ground and Air. Authorization required for Non-Emergency Medicare Services.
Non-Emergency Medical Transportation	Twenty-four one-way health related trips only. Trip limit of sixty mile radius one-way. Extra mileage up to eighty 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 restrictions apply.
Emergency Room	$0 Copay
Urgent Care	$0 Copay
Inpatient Hospital Stay (Acute and Psychiatric)	$0 Copay and Authorization required
Skilled Nursing Facility	$0 Copay and Authorization required
Home Health	$0 Copay and Authorization required
Diabetic Supplies	$0 Copay
SSBCI Flex Card and Non-SSBCI Flex Card	SSBCI Qualified Members receive $235 per month combined allowance for OTC, Home/Bathroom Safety, Food (SSBCI), Utility (SSBCI), Pay-at-the-Pump Gas (SSBCI). Members can use the $235 allowance to pay plan approved utility expenses or to purchase healthy foods or OTC at select retail locations, online, or via catalog; or Home/Bathroom Safety items via online catalog. Pay-at-the-Pump Gas requires card balance of at least $50 and a hold will be placed on the card until payment clears. Members may not pay for gas inside a store. Unused allowances expire at the end of the month. Fees and plan restrictions apply. Non-SSBCI Members receive $50 per month combined allowance for OTC and Home/Bathroom Safety. Members can use the $50 allowance to pay plan approved expenses for OTC items at select retail stores, online, or via catalog; or Home/Bathroom Safety items via online catalog. Unused allowances expire at the end of the month. Fees and plan restrictions apply.
Durable Medical Equipment, Prosthetic Devices, Medical Supplies	$0 Copay and Authorization required
Meal Benefit	Fourteen meals over seven days, no limit for the number of admissions. Beneficiary will be eligible for the benefit upon discharge from inpatient stay as monitored by the plan. Plan restrictions apply.
Fitness Benefit	The plan offers a fitness program membership beneficial for Medicare-eligible persons of all fitness levels. Members have access to fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. The program focuses on improving and maintaining strength, balance, and overall fitness.
Personal Emergency Response System (PERS)	Benefit coordinated through Highmark Health Options Health Case Management Department. Limited to one PERS device per member per lifetime.
Additional Telehealth Services	$0 copay
Part B Drugs	$0 Copay and Prior authorization required for certain prescription drugs
Medicare Covered Eye Exam	$0 Copay
Medicare Covered Eyewear	$0 Copay
Routine Eye Exam — Supplemental	$0 Copay; One visit per year
Routine Eyewear — Supplemental	$200 allowance for eyeglass frames OR contact lenses per year. 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
Routine Hearing Exams — Supplemental	$0 Copay; One visit per year
Routine Hearing Aids — Supplemental	Two hearing aids every three years (one aid per ear). Must see a TruHearing provider.
Medicare Dental Services	$0 Copay; Authorization may be required for Medicare covered services.
Comprehensive Dental — Supplemental	$2,500 every year; Amalgam or resin fillings unlimited. Crowns limited to two per year, one crown in five years per tooth; Two Endodontics Services per year; 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; Dentures are covered one per arch every year including a full denture, a partial denture or an immediate denture, and denture repairs; Simple extractions only.
Routine Dental — Supplemental	$2,500 every year (combined with Comprehensive); One oral exam every six months; Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months; Any combination of routine prophylaxis and periodontal maintenance (D1110 and D4910) totaling four per year.
Medicare Covered Chiropractic	$0 Copay and Authorization required
Routine Chiropractic	Not Covered
Medicare Covered Podiatry	$0 Copay
Routine Podiatry	$0 Copay; Six visits per year
Cardiac, Intensive Cardiac, Pulmonary Rehab and SET	$0 Copay
PART D DRUGS	
Part D Reduced Cost Sharing	Members will pay their LIS cost share for generic and brand name drugs covered under Highmark's formulary.

Products Overview

D-SNP Plan eligibility requirements

Highmark Wholecare (PA)		Highmark Blue Cross Blue Shield (DE)		Highmark Blue Cross Blue Shield (WV)
Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)	Highmark Health Options Duals (HMO SNP)	Highmark Health Options Duals Select (HMO SNP)	Highmark Health Options Duals (HMO SNP)
Live in service area	Live in service area	Live in service area	Live in service area	Live in service area
Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A	Entitled to Medicare Part A
Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B	Enrolled in Medicare Part B
Full Medicaid: QMB, QMB+, SLMB+, and FBDE	Partial Medicaid: SLMB, QI, and QMB	Full Medicaid: QMB+, SLMB+, and FBDE	Partial Medicaid: SLMB, QI, and QMB	Full Medicaid: QMB, QMB+, SLMB+, and FBDE

Eligibility descriptions

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only)	These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid.
QMBs with full Medicaid (QMB+)	These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.
Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only)	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.
SLMBs with full Medicaid (SLMB+)	These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.
Qualified Disabled and Working Individuals (QDWIs)	These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid.

Supplemental Benefits

SSBCI Benefits (Special Supplemental Benefits for the Chronically Ill)

For 2026, Highmark is now using the SSBCI model to administer flex card benefits. This means members must meet specific criteria to qualify for additional funds for Food, Utility, and Pay-At-The-Pump gas benefits. The member must have one or more chronic conditions and be at risk of adverse health outcomes.

All DSNP Members

Receive funds for OTC and Home/Bathroom Safety benefits on Day One of their enrollment, regardless of their SSBCI qualification. However, the amount of these funds will be less for those who don't have SSBCI qualification.

SSBCI Qualified Members

Receive additional funds for additional allowable expenses: Food, Utility, and Pay-At-The-Pump gas benefits.

Rollover

It's important to note that any unused funds will expire – Full Dual funds expire at the end of each month, while Partial Dual funds expire at the end of each quarter.

SSBCI Member Notifications and Qualification Process

During the pre-AEP period, Highmark notified all current members about their SSBCI qualification status for SSBCI flex benefits. If a current member didn't initially qualify, we will continue to work with them to determine eligibility and gather the necessary documentation to activate their Food, Utility, and Gas benefits and additional funds.

For new members, a clinician (doctor, nurse, etc.) can complete a Highmark Provider Attestation form confirming that the patient meets qualification criteria. Highmark provides instructions to Providers on how to complete this form and return to Highmark; members can also request a form and instructions to take to their Provider by calling Customer Service. Members will be informed once they are qualified and funds are activated. Highmark will also work internally to review member claims that can meet the SSBCI qualification needs and inform members when qualification status changes. Sales Agents should refrain from over promising on SSBCI benefit qualifications and allow Highmark to work with the member.

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 and WV) products. Ruby (PA) and Health Options Duals Select (DE) is once every five years.)

The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

Supplemental Benefits, cont.

Vision Benefit

Members will receive an allowance for frames or contacts. Standard lens options are covered in full for all plans.

Pennsylvania Diamond and Delaware Health Options Duals

- Members are eligible for select upgrades covered in full

Pennsylvania Ruby, Delaware Health Options Duals Select and West Virginia Health Options Duals

- Members are **not** eligible for select upgrades covered in full

Hearing Benefit

We offer top-notch hearing benefits for all Highmark D-SNP members including:

- Up to two TruHearing branded hearing aids every three years.
- $0 Copay for routine hearing exams and hearing aid fitting.

Over-The-Counter Benefit

Members can spend part of the flex card benefit and is part of the non-SSBCI combined monthly/quarterly allowance on Brand Name and Generic OTC products, which can be ordered online or via catalog.

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

Pennsylvania Diamond and West Virginia Health Options Duals 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.

Pennsylvania Diamond and West Virginia Health Options Duals members receive 24 one-way non-emergency medical trips.

All other Highmark D-SNP plans do not include transportation benefits.

SilverSneakers

Members can stay active and social with the Highmark Fitness Benefit, now including access to the SilverSneakers® Fitness program. With SilverSneakers members can take classes and use exercise equipment and other amenities, at no additional cost at thousands of participating locations. Enroll in as many locations as you like, at any time. Members also have access to a large variety of virtual classes taught by instructors who specialize in older adult fitness with SilverSneakers LIVE. Get started today by visiting **silversneakers.com** or calling **1-888-423-4632** (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.

D-SNP Pharmacy Networks

PA

Highmark Wholecare D-SNP Pharmacy Network

giant eagle, Costco Wholesale, weis, CVS pharmacy, GIANT, Walmart, Walgreens, Target

DE

Highmark Blue Cross Blue Shield Delaware D-SNP Pharmacy Network

Costco Wholesale, GIANT, Harris Teeter, CVS pharmacy, Save-on Pharmacy, Walmart, Walgreens, ACME, ivira

WV

Highmark Blue Cross Blue Shield West Virginia D-SNP Pharmacy Network

Walgreens, CVS pharmacy, Walmart, weis, sam's club, FRUTH, Target, Kroger, giant eagle

Select local pharmacies are also in network.

Changes to our pharmacy network may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Highmark Wholecare D-SNP In-Network Hospitals

PA

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Adams County		
Wellspan Gettysburg Hospital	✔	✔
Allegheny County		
AHN Brentwood Neighborhood Hospital	✔	✔
AHN Forbes Hospital	✔	✔
AHN McCandless Neighborhood Hospital	✔	✔
AHN Observation Group	✔	✔
AHN West Penn Hospital	✔	✔
AHN Wexford Hospital	✔	✔
Allegheny General Hospital	✔	✔
Alle-Kiski Medical Center	✔	✔
Children's Hospital of Pittsburgh	✔	✔
Heritage Valley Sewickley	✔	✔
Jefferson Regional Medical Center	✔	✔
St. Clair Hospital — Outpatient/Inpatient	✔	✔
UPMC East	✔	✔
UPMC Magee — Womens Hospital	✔	✔
UPMC McKeesport Hospital	✔	✔
UPMC Mercy	✔	✔
UPMC Passavant	✔	✔
UPMC Shadyside	✔	✔
UPMC St. Margaret	✔	✔
Armstrong County		
Armstrong County Memorial Hospital	✔	✔
Beaver County		
Heritage Valley Beaver	✔	✔
Bedford County		
UPMC Bedford	✔	✔
Berks County		
Reading Hospital and Medical Center	✔	✔
Reading Hospital — Weight Loss Surgery	✔	✔
Penn State Health St. Joseph Medical Center	✔	✔
Surgical Institute of Reading	✔	✔
Blair County		
Conemaugh Nason Medical Center	✔	✔
Penn Highlands Tyrone	✔	✔
UPMC Altoona	✔	✔
Bradford County		
Guthrie Troy Community Hospital	✔	✔
Guthrie Robert Packer Hospital	✔	✔
Guthrie Robert Packer Hospital — Towanda Campus	✔	✔

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Highmark Wholecare D-SNP In-Network Hospitals

PA, cont.

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Bucks County		
Aria Health — Bucks Campus	✔	✔
Avenues Recovery Medical Center at Valley Forge	✔	✔
Lower Bucks Hospital	✔	✔
St. Luke's Hospital — Quakertown Campus	✔	✔
St. Mary Medical Center	✔	✔
Butler County		
Butler Memorial Hospital	✔	✔
Cambria County		
Conemaugh Valley Memorial Hospital	✔	✔
Conemaugh Miners Medical Center	✔	✔
Carbon County		
St. Luke's Hospital — Lehighton Campus	✔	✔
St. Luke's Hospital — Carbon Campus	✔	✔
Centre County		
Mount Nittany Medical Center	✔	✔
Chester County		
Paoli Hospital	✔	✔
Penn Medicine Chester County Hospital	✔	✔
Phoenixville Hospital	✔	✔
Clarion County		
Clarion Hospital	✔	✔
Clearfield County		
Penn Highlands Clearfield	✔	✔
Penn Highlands Dubois	✔	✔
Clinton County		
Bucktail Medical Center	✔	✔
Crawford County		
Meadville Medical Center	✔	✔
Titusville Area Hospital	✔	✔
Cumberland County		
Penn State Health Holy Spirit Medical Center	✔	✔
Holy Spirit Silver Creek Mediplex	✔	✔
Penn State Health Hampden Medical Center	✔	✔
UPMC Carlisle	✔	✔
Dauphin County		
Penn State Health Milton S. Hershey Medical Center	✔	✔
UPMC Community Osteopathic	✔	✔
Delaware County		
Mercy Catholic Medical Center Fitzgerald Campus	✔	✔
Main Line Health — Riddle Hospital	✔	✔
Crozer Health — Springfield Hospital	✔	✔

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Highmark Wholecare D-SNP In-Network Hospitals

PA, cont.

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Elk County		
Penn Highlands Elk	✓	✓
Erie County		
AHN Saint Vincent Hospital	✓	✓
LECOM Health — Corry Memorial Hospital	✓	✓
LECOM Health — Millcreek Community Hospital	✓	✓
UPMC Hamot	✓	✓
Fayette County		
WVU Uniontown Hospital	✓	✓
Franklin County		
WellSpan Chambersburg Hospital	✓	✓
WellSpan Waynesboro Hospital	✓	✓
Fulton County		
Fulton County Medical Center	✓	✓
Greene County		
Washington Health System Greene	✓	✓
Huntingdon County		
Penn Highlands Huntingdon	✓	✓
Indiana County		
Indiana Regional Medical Center	✓	✓
Jefferson County		
Penn Highlands Brookville	✓	✓
Punxsutawney Area Hospital	✓	✓
Lackawanna County		
Lehigh Valley Hospital — Dickson City	✓	✓
Lancaster County		
Ephrata Community Hospital	✓	✓
Lancaster Behavioral Health Hospital	✓	✓
Lancaster General Hospital	✓	✓
Penn State Health Lancaster Medical Center	✓	✓
UPMC Lititz	✓	✓
Lawrence County		
UPMC Jameson	✓	✓
Lebanon County		
WellSpan Good Samaritan Hospital	✓	✓
Lehigh County		
Lehigh Valley Hospital	✓	✓
Lehigh Valley Hospital Coordinated Health Allentown	✓	✓
St. Luke's Hospital — Allentown	✓	✓
Luzerne County		
Lehigh Valley Hospital — Hazleton	✓	✓

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Highmark Wholecare D-SNP In-Network Hospitals

PA, cont.

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Lycoming County		
UPMC Muncy	✓	✓
UPMC Williamsport	✓	✓
McKean County		
UPMC Kane	✓	✓
Mercer County		
AHN Grove City Hospital	✓	✓
Edgewood Surgical Hospital	✓	✓
UPMC Horizon	✓	✓
Monroe County		
Lehigh Valley Hospital — Pocono	✓	✓
St. Luke's Hospital — Monroe Campus	✓	✓
Montgomery County		
Jefferson Einstein Montgomery Hospital	✓	✓
Lankenau Medical Center	✓	✓
Pottstown Hospital	✓	✓
Suburban Community Hospital	✓	✓
Northampton County		
Lehigh Valley Hospital — Muhlenberg	✓	✓
Lehigh Valley Hospital Coordinated Health Bethlehem	✓	✓
St. Luke's Hospital — Anderson	✓	✓
St. Luke's Hospital — Bethlehem Campus	✓	✓
St. Lukes Hospital — Easton Campus	✓	✓
Philadelphia County		
Albert Einstein Medical Center	✓	✓
Aria Health — Frankford Campus	✓	✓
Aria Health — Torresdale Campus	✓	✓
Chestnut Hill Hospital	✓	✓
Children's Hospital of Philadelphia	✓	✓
Holy Redeemer Hospital	✓	✓
Hospital of the University of Pennsylvania	✓	✓
Jeanes Hospital	✓	✓
Kensington Hospital	✓	✓
Mercy Catholic Hospital — Philadelphia Campus	✓	✓
Nazareth Hospital	✓	✓
Penn Presbyterian Medical Center	✓	✓
Pennsylvania Hospital	✓	✓
Roxborough Memorial Hospital	✓	✓
Temple University Hospital	✓	✓
Wills Eye Hospital	✓	✓
Potter County		
Charles Cole Memorial Hospital	✓	✓

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Highmark Wholecare D-SNP In-Network Hospitals

PA, cont.

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Schuylkill County		
Geisinger St. Luke's Hospital	✔	✔
Lehigh Valley Hospital — Schuylkill East Norwegian Street	✔	✔
St. Luke's Hospital — Miners Campus	✔	✔
Somerset County		
Meyersdale Medical Center	✔	✔
UPMC Somerset	✔	✔
Chan Soon-Shiong Medical Center at Windber	✔	✔
Tioga County		
UPMC Wellsboro	✔	✔
Union County		
Evangelical Community Hospital	✔	✔
Venango County		
UPMC Northwest	✔	✔
Warren County		
Warren General Hospital	✔	✔
Washington County		
AHN Canonsburg Hospital	✔	✔
Washington Health System	✔	✔
Penn Highlands Mon Valley	✔	✔
Westmoreland County		
AHN Hempfield Neighborhood Hospital	✔	✔
Latrobe Area Hospital	✔	✔
Westmoreland Hospital	✔	✔
Frick Hospital	✔	✔
York County		
OSS Orthopaedic Hospital	✔	✔
UPMC Hanover	✔	✔
UPMC Memorial	✔	✔
WellSpan Philhaven Child Partial Hospitalization	✔	✔
WellSpan York Hospital	✔	✔

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Highmark Wholecare D-SNP In-Network Hospitals

Delaware

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
New Castle County		
ChristianaCare Health Services Inc.	✔	✔

New York

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Cattaraugus County		
Olean General Hospital	✔	✔
Cortland County		
Guthrie Cortland Medical Center — Cancer Center	✔	✔
Steuben County		
Guthrie Corning Hospital	✔	✔

West Virginia

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Berkeley County		
Berkeley Medical Center	✔	✔
Jefferson County		
Jefferson Medical Center	✔	✔
Marshall County		
Reynolds Memorial Hospital	✔	✔
Mineral County		
Potomac Valley Hospital of WV	✔	✔
Monongalia County		
J.W. Ruby Memorial Hospital	✔	✔
Upshur County		
WVU Medicine — St. Joseph's Hospital	✔	✔
Wetzel County		
WVU Medicine — Wetzel County Hospital	✔	✔

New Jersey

Facility Name	Medicare Assured Diamond (HMO D-SNP)	Medicare Assured Ruby (HMO D-SNP)
Morris County		
Morristown Medical Center — AHS Hospital Corp.	✔	✔
Sussex County		
Newton Medical Center — AHS Hospital Corp.	✔	✔
Union County		
Overlook Medical Center — AHS Hospital Corp.	✔	✔
Warren County		
Hackettstown Medical Center — AHS Hospital Corp.	✔	✔

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Highmark Blue Cross Blue Shield Delaware D-SNP In-Network Hospitals

Delaware

Facility Name
Kent County
Bayhealth Hospital — Kent Campus
PAM Health Rehabilitation Hospital of Dover
Dover Behavioral Health
New Castle County
ChristianaCare — Christiana Hospital
ChristianaCare — Wilmington Hospital
Rockford Center
Sussex County
Beebe Healthcare — Abessinio Health Campus
Beebe Healthcare — Margaret H. Rollins Lewes Campus
Beebe Healthcare — South Coastal Health Campus
PAM Health Rehabilitation Hospital of Georgetown
SUN Behavioral Health

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

Highmark Blue Cross Blue Shield West Virginia D-SNP In-Network Hospitals

West Virginia

Facility Name
Barbour
Broaddus Hospital
Boone
Boone Memorial Hospital
Cabell
Cabell Huntington Hospital
St. Mary's Medical Center
Calhoun
Minnie Hamilton Health Care Center Inc.
Fayette
Montgomery General Hospital
Harrison
Highland — Clarksburg Hospital
Kanawha
Charleston Area Medical Center
Lewis
Stonewall Jackson Memorial Hospital Company
William R. Sharpe, Jr. Hospital
Logan
Logan General Hospital
Mason
Pleasant Valley Hospital, Inc.
McDowell
Welch Community Hospital
Welch Community Hospital RHC
Morgan
War Memorial Hospital Incorporated
Pocahontas
Pocahontas Memorial Hospital
Preston
Preston Memorial Hospital
Raleigh
Beckley Arh Hospital
Raleigh General Hospital

Facility Name
Randolph
Davis Medical Center
Laurel Place
Roane
Roane General Hospital
Summers
Summers County Arh Hospital
Taylor
Grafton City Hospital
Webster
Webster Memorial Hospital

Out-of-state provider

Facility Name
Belmont, OH
East Ohio Regional Hospital
Buchanan, VA
Buchanan General Hospital
Buchanan General Hospital Professional Services
Frederick, VA
Winchester Medical Center
Mahoning, OH
Belmont Pines Hospital
Page, VA
Page Memorial Hospital
Pike, KY
Pikeville Medical Center
Tug Valley ARH Regional Medical Center
Shenandoah, VA
Shenandoah Memorial Hospital
Washington, OH
Marietta Memorial Hospital
Selby General Hospital

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

PRODUCTS AND PRICING BY COUNTY

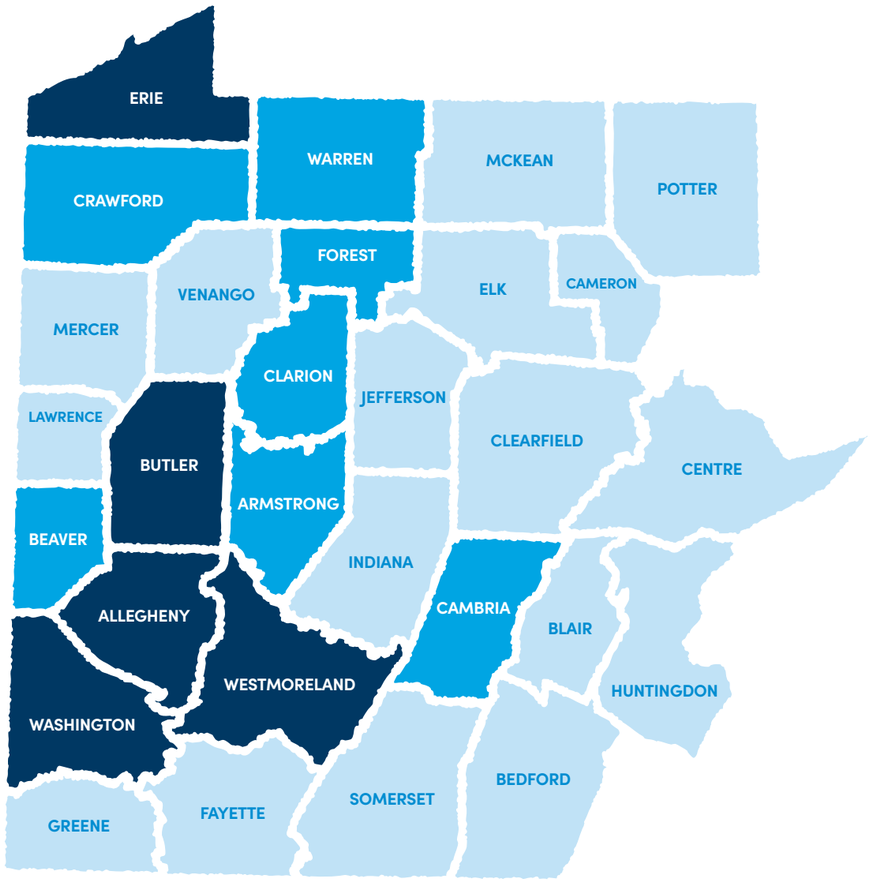
ACA Individual Market

WPA

Together Blue EPO, my Direct Blue EPO, and my Blue Access PPO

my Direct Blue EPO and my Blue Access PPO

my Blue Access PPO



WPA, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	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
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test — Lab Services	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test — X-rays	$0 after deductible	$0 after deductible	$180 copay
Urgent Care	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary	$0 after deductible	$0 after deductible	Tier 1 drugs: $15 (not subject to deductible) All other tiers: 50% after deductible
Integrated Adult Dental and Vision Available	No	No	Yes

** This plan is HSA-eligible*

WPA, cont.

Coverage Level	Silver 6000	Silver 0	Premier Silver 0	Gold 1700 HSA
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: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Diagnostic Test — Lab Services	$55 copay	$60 copay	$60 copay	$15 copay after deductible
Diagnostic Test — X-rays	$125 copay	$175 copay	$175 copay	$15 copay after deductible
Urgent Care	$100 copay	$100 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	Yes	Yes	No

*** Off-Exchange only*

WPA, cont.

Coverage Level	Gold 1500	Gold 0	Premier Gold 0	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 my Direct Blue EPO** my Blue Access PPO**
In-Network Deductible	Individual: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	Virtual: $0 copay In-office: $35 copay	$20 copay	$15 copay	$0 copay
Specialist Visit	Virtual: $0 copay In-office: $35 copay	$20 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	Virtual: $0 copay In-office: $35 copay	$20 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$35 copay	$20 copay	$40 copay	$0 copay
Diagnostic Test — Lab Services	$40 copay	$35 copay	$35 copay	$0 copay
Diagnostic Test — X-rays	$40 copay	$35 copay	$90 copay	$0 copay
Urgent Care	Virtual: $0 copay In-office: $70 copay	$40 copay	$30 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay
Hospital Inpatient — including facility and professional	$725 copay after deductible	$725 copay	$525 copay	$325 copay
Pharmacy Summary	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	Yes	Yes	Yes	Yes

*** Off-Exchange only*
**** Virtual Choice offering*

WPA — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Silver 3000**	**Premier Silver 0**	**Silver 0**	**Premier 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: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400	Individual: $3,200 Family: $6,400	Individual: $3,300 Family: $6,600
Primary Care Visit	$55 copay	$45 copay	$15 copay	$0 copay
Specialist Visit	$55 copay	$45 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$45 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$45 copay	$15 copay	$15 copay
Diagnostic Test — Lab Services	$55 copay	$60 copay	$30 copay	$60 copay
Diagnostic Test — X-rays	$125 copay	$175 copay	$50 copay	$90 copay
Urgent Care	$100 copay	$90 copay	$30 copay	$10 copay
Emergency Services	$750 copay after deductible	$1,250 copay	$375 copay	$500 copay
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$450 copay	$550 copay
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible/	$5/$30/$250/50%	$0/$10/$50/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	No	Yes	No	Yes

WPA — Extra Savings

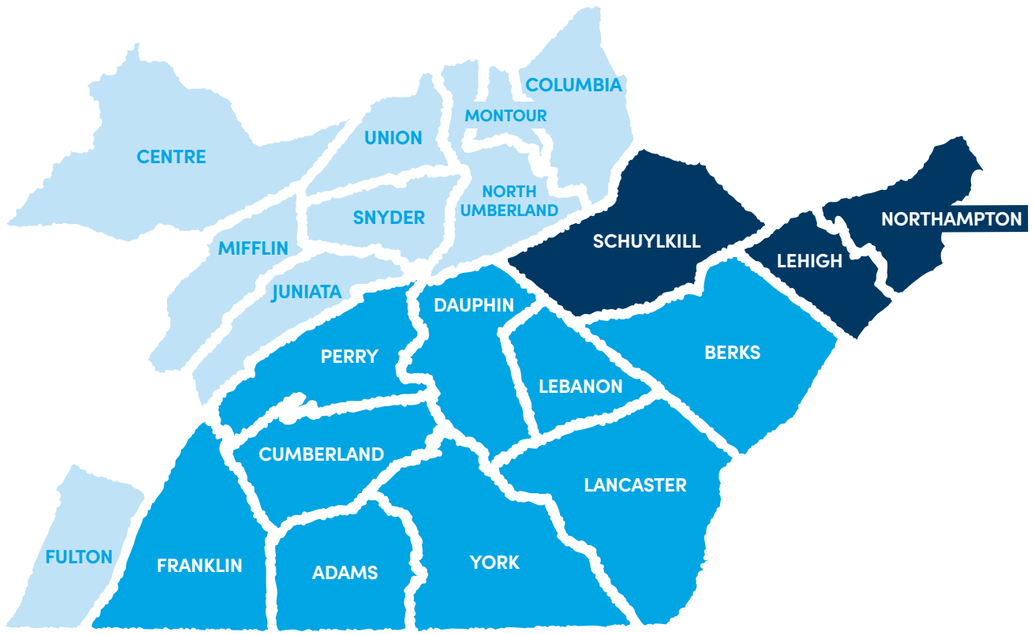
Income Level	138% – 149% FPL	
Coverage Level	**Silver 0**	**Premier Silver 0**
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500
Primary Care Visit	$1 copay	$0 copay
Specialist Visit	$1 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$1 copay	$0 copay
Diagnostic Test — Lab Services	$1 copay	$0 copay
Diagnostic Test — X-rays	$1 copay	$0 copay
Urgent Care	$5 copay	$5 copay
Emergency Services	$125 copay	$125 copay
Hospital Inpatient — including facility and professional	$175 copay	$175 copay
Pharmacy Summary	$0/$1/$5/50%	$0/$1/$5/50%
Integrated Adult Dental and Vision Available	No	Yes

CPA

my Direct Blue Lehigh Valley EPO and my Blue Access PPO

my Direct Blue EPO and my Blue Access PPO

my Blue Access PPO



CPA, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	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
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test — Lab Services	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test — X-rays	$0 after deductible	$0 after deductible	$180 copay
Urgent Care	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary	$0 after deductible	$0 after deductible	Tier 1 drugs: $15 (not subject to deductible) All other tiers: 50% after deductible
Integrated Adult Dental and Vision Available	No	No	Yes

** This plan is HSA-eligible*

CPA, cont.

Coverage Level	Silver 6000	Silver 0**	Premier Silver 0	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	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$50 copay	$45 copay	$15 copay after deductible
Diagnostic Test — Lab Services	$55 copay	$60 copay	$60 copay	$15 copay after deductible
Diagnostic Test — X-rays	$125 copay	$175 copay	$175 copay	$15 copay after deductible
Urgent Care	$100 copay	$100 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	Yes	Yes	No

*** Off-Exchange only*

CPA, cont.

Coverage Level	Gold 1500	Gold 0	Premier Gold 0	Premier Platinum 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: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	$35 copay	$20 copay	$15 copay	$0 copay
Specialist Visit	$35 copay	$20 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$35 copay	$20 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$35 copay	$20 copay	$40 copay	$0 copay
Diagnostic Test — Lab Services	$40 copay	$35 copay	$35 copay	$0 copay
Diagnostic Test — X-rays	$40 copay	$35 copay	$90 copay	$0 copay
Urgent Care	$70 copay	$40 copay	$30 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay
Hospital Inpatient — including facility and professional	$725 copay after deductible	$725 copay	$525 copay	$325 copay
Pharmacy Summary	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	Yes	Yes	Yes	Yes

*** Off-Exchange only*

CPA — Extra Savings

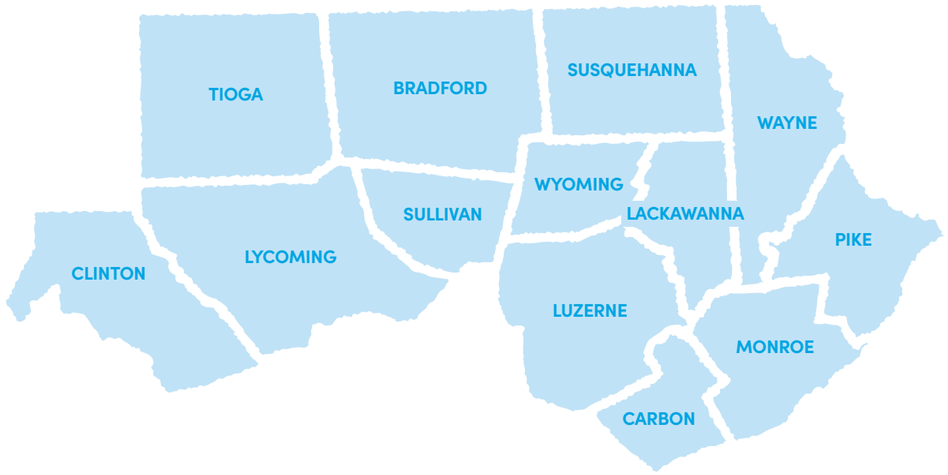
Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Silver 3000**	**Premier Silver 0**	**Silver 0**	**Premier Silver 0**
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400	Individual: $3,200 Family: $6,400	Individual: $3,300 Family: $6,600
Primary Care Visit	$55 copay	$45 copay	$15 copay	$0 copay
Specialist Visit	$55 copay	$45 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$45 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$45 copay	$15 copay	$15 copay
Diagnostic Test — Lab Services	$55 copay	$60 copay	$30 copay	$60 copay
Diagnostic Test — X-rays	$125 copay	$175 copay	$50 copay	$90 copay
Urgent Care	$100 copay	$90 copay	$30 copay	$10 copay
Emergency Services	$750 copay after deductible	$1,250 copay	$375 copay	$500 copay
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$450 copay	$550 copay
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$0/$10/$50/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	No	Yes	No	Yes

CPA — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Silver 0**	**Premier 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500
Primary Care Visit	$1 copay	$0 copay
Specialist Visit	$1 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$1 copay	$0 copay
Diagnostic Test — Lab Services	$1 copay	$0 copay
Diagnostic Test — X-rays	$1 copay	$0 copay
Urgent Care	$5 copay	$5 copay
Emergency Services	$125 copay	$125 copay
Hospital Inpatient — including facility and professional	$175 copay	$175 copay
Pharmacy Summary	$0/$1/$5/50%	$0/$1/$5/50%
Integrated Adult Dental and Vision Available	No	Yes

NEPA

my Priority Blue Flex PPO



NEPA, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	Bronze 3800*
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $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: $65 copay Standard: $80 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	Enhanced: $0 after deductible Standard: $0 after deductible	Enhanced: $65 copay Standard: $65 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	Enhanced: $0 after deductible Standard: $0 after deductible	Enhanced: $65 copay Standard: $80 copay
Diagnostic Test — Lab Services	$0 after deductible	Enhanced: $0 after deductible Standard: $0 after deductible	Enhanced: $65 copay Standard: $95 copay
Diagnostic Test — X-rays	$0 after deductible	Enhanced: $0 after deductible Standard: $0 after deductible	Enhanced: $180 copay Standard: $225 copay
Urgent Care	$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: 50% after deductible Standard: 50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	Enhanced: $0 after deductible Standard: $0 after deductible	Enhanced: 50% after deductible Standard: 60% after deductible
Pharmacy Summary	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$15 not subject to deductible/ 50% after deductible/ 50% after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	No	Yes

** This plan is HSA-eligible*

NEPA, cont.

Coverage Level	Silver 6000	Silver 0**	Premier Silver 0	Gold 1700 HSA
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: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network Out-of-Pocket Maximum	Individual: $8,400 Family: $16,800	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,200 Family: $14,400
Primary Care Visit	Enhanced: $55 copay Standard: $65 copay	Enhanced: $50 copay Standard: $70 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay after deductible Standard: $20 copay after deductible
Specialist Visit	Enhanced: $55 copay Standard: $65 copay	Enhanced: $50 copay Standard: $70 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay after deductible Standard: $20 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	Enhanced: $55 copay Standard: $55 copay	Enhanced: $50 copay Standard: $50 copay	Enhanced: $45 copay Standard: $45 copay	Enhanced: $15 copay after deductible Standard: $15 copay after deductible
Speech, Physical, Occupational, and Chiropractic Care Therapy	Enhanced: $55 copay Standard: $65 copay	Enhanced: $50 copay Standard: $70 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay after deductible Standard: $20 copay after deductible
Diagnostic Test — Lab Services	Enhanced: $55 copay Standard: $70 copay	Enhanced: $60 copay Standard: $75 copay	Enhanced: $60 copay Standard: $75 copay	Enhanced: $15 copay after deductible Standard: $20 copay after deductible

*** Off-Exchange only*

NEPA, cont.

Coverage Level	Silver 6000	Silver 0**	Premier Silver 0	Gold 1700 HSA
Diagnostic Test — X-rays	Enhanced: $125 copay Standard: $150 copay	Enhanced: $175 copay Standard: $225 copay	Enhanced: $175 copay Standard: $225 copay	Enhanced: $15 copay after deductible Standard: $20 copay after deductible
Urgent Care	Enhanced: $100 copay Standard: $100 copay	Enhanced: $100 copay Standard: $100 copay	Enhanced: $90 copay Standard: $90 copay	Enhanced: $30 copay after deductible Standard: $30 copay after deductible
Emergency Services	Enhanced: $750 copay after deductible Standard: $750 copay after deductible	Enhanced: $1,250 copay Standard: $1,250 copay	Enhanced: $1,250 copay Standard: $1,250 copay	Enhanced: $250 copay after deductible Standard: $250 copay after deductible
Hospital Inpatient — including facility and professional	Enhanced: $1,125 copay after deductible Standard: $1,375 copay after deductible	Enhanced: $2,500 copay Standard: $3,000 copay	Enhanced: $2,500 copay Standard: $3,000 copay	Enhanced: $450 copay after deductible Standard: $550 copay after deductible
Pharmacy Summary	$10 not subject to deductible/ $30 not subjec to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	Yes	Yes	No

*** Off-Exchange only*

NEPA, cont.

Coverage Level	Gold 1500	Gold 0	Premier Gold 0	Premier Platinum 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: $1,500 Family: $3,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	Enhanced: $35 copay Standard: $40 copay	Enhanced: $20 copay Standard: $30 copay	Enhanced: $15 copay Standard: $25 copay	Enhanced: $0 copay Standard: $5 copay
Specialist Visit	Enhanced: $35 copay Standard: $40 copay	Enhanced: $20 copay Standard: $30 copay	Enhanced: $15 copay Standard: $25 copay	Enhanced: $0 copay Standard: $5 copay
Outpatient Mental Health and Substance Abuse Visits	Enhanced: $35 copay Standard: $35 copay	Enhanced: $20 copay Standard: $20 copay	Enhanced: $15 copay Standard: $15 copay	Enhanced: $0 copay Standard: $0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	Enhanced: $35 copay Standard: $40 copay	Enhanced: $20 copay Standard: $30 copay	Enhanced: $40 copay Standard: $50 copay	Enhanced: $0 copay Standard: $5 copay
Diagnostic Test — Lab Services	Enhanced: $40 copay Standard: $50 copay	Enhanced: $35 copay Standard: $50 copay	Enhanced: $35 copay Standard: $50 copay	Enhanced: $0 copay Standard: $5 copay
Diagnostic Test — X-rays	Enhanced: $40 copay Standard: $50 copay	Enhanced: $35 copay Standard: $50 copay	Enhanced: $90 copay Standard: $115 copay	Enhanced: $0 copay Standard: $5 copay
Urgent Care	Enhanced: $70 copay Standard: $70 copay	Enhanced: $40 copay Standard: $40 copay	Enhanced: $30 copay Standard: $30 copay	Enhanced: $5 copay Standard: $5 copay
Emergency Services	Enhanced: $450 copay Standard: $450 copay	Enhanced: $400 copay Standard: $400 copay	Enhanced: $350 copay Standard: $350 copay	Enhanced: $100 copay Standard: $100 copay
Hospital Inpatient — including facility and professional	Enhanced: $725 copay after deductible Standard: $875 copay after deductible	Enhanced: $725 copay Standard: $875 copay	Enhanced: $525 copay Standard: $650 copay	Enhanced: $325 copay Standard: $400 copay
Pharmacy Summary	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	Yes	Yes	Yes	Yes

*** Off-Exchange only*

NEPA — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Silver 3000**	**Premier Silver 0**	**Silver 0**	**Premier 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: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $6,900 Family: $13,800	Individual: $7,700 Family: $15,400	Individual: $3,200 Family: $6,400	Individual: $3,300 Family: $6,600
Primary Care Visit	Enhanced: $55 copay Standard: $65 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay Standard: $25 copay	Enhanced: $0 copay Standard: $15 copay
Specialist Visit	Enhanced: $55 copay Standard: $65 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay Standard: $25 copay	Enhanced: $0 copay Standard: $15 copay
Outpatient Mental Health and Substance Abuse Visits	Enhanced: $55 copay Standard: $55 copay	Enhanced: $45 copay Standard: $45 copay	Enhanced: $15 copay Standard: $15 copay	Enhanced: $0 copay Standard: $0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	Enhanced: $55 copay Standard: $65 copay	Enhanced: $45 copay Standard: $55 copay	Enhanced: $15 copay Standard: $30 copay	Enhanced: $15 copay Standard: $30 copay
Diagnostic Test — Lab Services	Enhanced: $55 copay Standard: $70 copay	Enhanced: $60 copay Standard: $75 copay	Enhanced: $30 copay Standard: $35 copay	Enhanced: $60 copay Standard: $80 copay
Diagnostic Test — X-rays	Enhanced: $125 copay Standard: $150 copay	Enhanced: $175 copay Standard: $225 copay	Enhanced: $50 copay Standard: $60 copay	Enhanced: $90 copay Standard: $115 copay
Urgent Care	Enhanced: $100 copay Standard: $100 copay	Enhanced: $90 copay Standard: $90 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 — including facility and professional	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: $550 copay Standard: $650 copay
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$0/$10/$50/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	No	Yes	No	Yes

NEPA — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Silver 0**	**Premier 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500
Primary Care Visit	Enhanced: $1 copay Standard: $5 copay	Enhanced: $0 Standard: $5
Specialist Visit	Enhanced: $1 copay Standard: $5 copay	Enhanced: $0 copay Standard: $5 copay
Outpatient Mental Health and Substance Abuse Visits	Enhanced: $1 copay Standard: $1 copay	Enhanced: $0 copay Standard: $0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	Enhanced: $1 copay Standard: $5 copay	Enhanced: $0 copay Standard: $5 copay
Diagnostic Test — Lab Services	Enhanced: $1 copay Standard: $5 copay	Enhanced: $0 copay Standard: $5 copay
Diagnostic Test — X-rays	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: $125 copay Standard: $125 copay	Enhanced: $125 copay Standard: $125 copay
Hospital Inpatient — including facility and professional	Enhanced: $175 copay Standard: $215 copay	Enhanced: $175 copay Standard: $215 copay
Pharmacy Summary	$0/$1/$5/50%	$0/$1/$5/50%
Integrated Adult Dental and Vision Available	No	Yes

SEPA

my Blue Access PPO

SEPA, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	Bronze 3800*
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $3,800 Family: $7,600
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $9,900 Family: $19,800
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$65 copay
Specialist Visit	$0 after deductible	$0 after deductible	$65 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$65 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	$0 after deductible	$65 copay
Diagnostic Test — Lab Services	$0 after deductible	$0 after deductible	$55 copay/$105 copay
Diagnostic Test — X-rays	$0 after deductible	$0 after deductible	$125 copay/$250 copay
Urgent Care	$0 after deductible	$0 after deductible	$100 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$15 not subject to deductible/ 50% after deductible/ 50% after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	No	Yes

** This plan is HSA-eligible*

SEPA, cont.

Coverage Level	Silver 6000	Silver 0	Premier Silver 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: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,700 Family: $3,400
In-Network Out-of-Pocket Maximum	Individual: $8,600 Family: $17,200	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400	Individual: $7,500 Family: $15,000
Primary Care Visit	$55 copay	$45 copay	$45 copay	$15 copay after deductible
Specialist Visit	$55 copay	$45 copay	$45 copay	$15 copay after deductible
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$45 copay	$45 copay	$15 copay after deductible
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$45 copay	$45 copay	$15 copay after deductible
Diagnostic Test — Lab Services	$50 copay/$75 copay	$55 copay/$105 copay	$55 copay/$105 copay	$15 copay after deductible
Diagnostic Test — X-rays	$90 copay/$150 copay	$125 copay/$250 copay	$125 copay/$250 copay	$15 copay after deductible
Urgent Care	$100 copay	$90 copay	$90 copay	$30 copay after deductible
Emergency Services	$750 copay after deductible	$1,250 copay	$1,250 copay	$250 copay after deductible
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$2,500 copay	$450 copay after deductible
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$5/$30/$250/50%	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible
Integrated Adult Dental and Vision Available	No	Yes	Yes	No

*** Off-Exchange only*

SEPA, cont.

Coverage Level	Gold 1500	Gold 0	Premier Gold 0	Premier Platinum 0
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: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,500 Family: $15,000	Individual: $6,900 Family: $13,800	Individual: $5,000 Family: $10,000
Primary Care Visit	$35 copay	$20 copay	$15 copay	$0 copay
Specialist Visit	$35 copay	$20 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$35 copay	$20 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$35 copay	$20 copay	$40 copay	$0 copay
Diagnostic Test — Lab Services	$35 copay/$60 copay	$30 copay/$55 copay	$30 copay/$55 copay	$0 copay/$0 copay
Diagnostic Test — X-rays	$35 copay/$60 copay	$30 copay/$55 copay	$80 copay/$130 copay	$0 copay/$0 copay
Urgent Care	$70 copay	$40 copay	$30 copay	$5 copay
Emergency Services	$450 copay	$400 copay	$350 copay	$100 copay
Hospital Inpatient — including facility and professional	$725 copay after deductible	$725 copay	$525 copay	$325 copay
Pharmacy Summary	$0/$30/$150/50%	$0/$30/$150/50%	$0/$25/$75/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	Yes	Yes	Yes	Yes

*** Off-Exchange only*

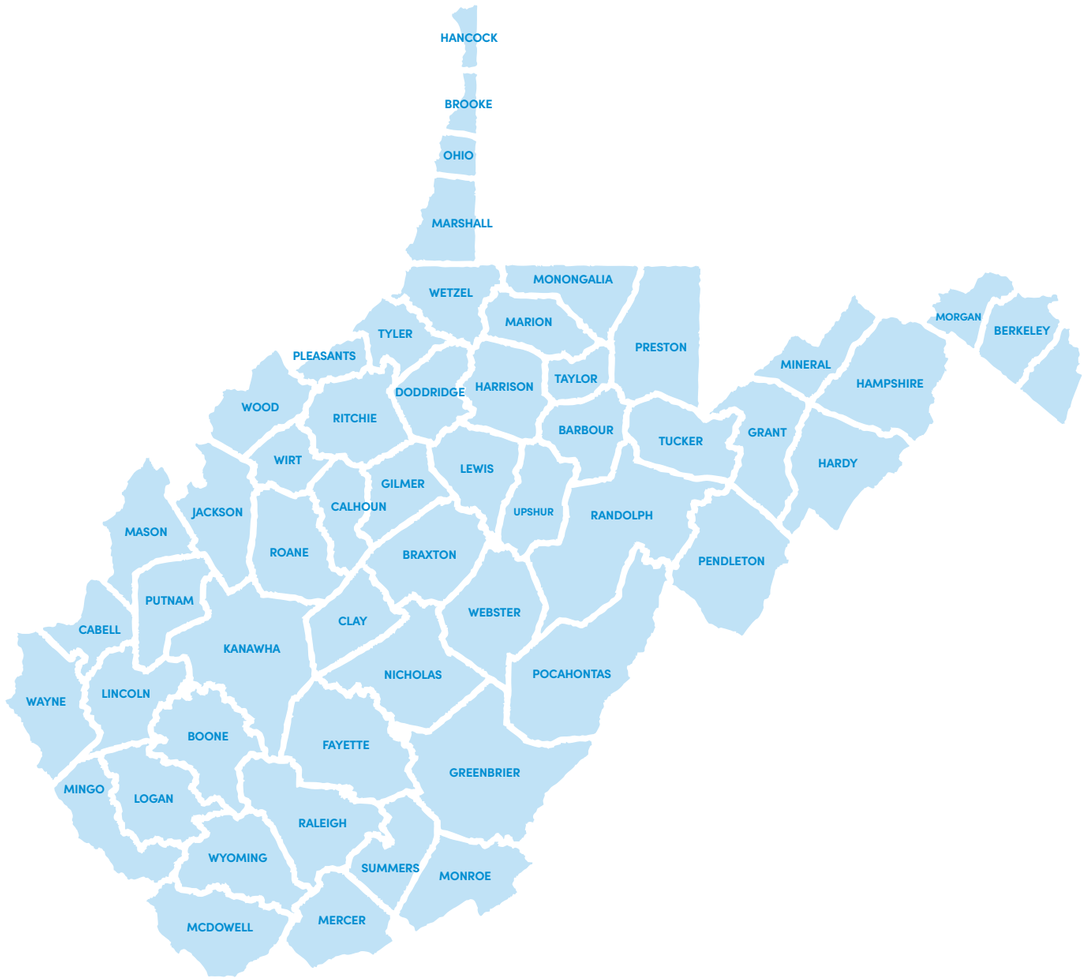
SEPA — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Silver 3000**	**Premier Silver 0**	**Silver 0**	**Premier Silver 0**
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $7,700 Family: $15,400	Individual: $3,200 Family: $6,400	Individual: $3,300 Family: $6,600
Primary Care Visit	$55 copay	$45 copay	$15 copay	$0 copay
Specialist Visit	$55 copay	$45 copay	$15 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$55 copay	$45 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$55 copay	$45 copay	$15 copay	$15 copay
Diagnostic Test — Lab Services	$50 copay/$75 copay	$55 copay/$105 copay	$25 copay/$50 copay	$55 copay/$80 copay
Diagnostic Test — X-rays	$90 copay/$150 copay	$125 copay/$250 copay	$50 copay/$75 copay	$80 copay/$130 copay
Urgent Care	$100 copay	$90 copay	$30 copay	$10 copay
Emergency Services	$750 copay after deductible	$1,250 copay	$375 copay	$500 copay
Hospital Inpatient — including facility and professional	$1,125 copay after deductible	$2,500 copay	$450 copay	$550 copay
Pharmacy Summary	$10 not subject to deductible/ $30 not subject to deductible/ $250 after deductible/ 50% after deductible	$5/$30/$250/50%	$0/$10/$50/50%	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	No	Yes	No	Yes

SEPA — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Silver 0**	**Premier 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: $1,300 Family: $2,600	Individual: $1,250 Family: $2,500
Primary Care Visit	$1 copay	$0 copay
Specialist Visit	$1 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$1 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$1 copay	$0 copay
Diagnostic Test — Lab Services	$0 copay/$5 copay	$0 copay/$0 copay
Diagnostic Test — X-rays	$0 copay/$5 copay	$0 copay/$0 copay
Urgent Care	$5 copay	$5 copay
Emergency Services	$125 copay	$125 copay
Hospital Inpatient — including facility and professional	$175 copay	$175 copay
Pharmacy Summary	$0/$1/$5/50%	$0/$1/$5/50%
Integrated Adult Dental and Vision Available	No	Yes

WV



WV, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	Standard Bronze 7500*
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $7,500 Family: $15,000
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $10,000 Family: $20,.000
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$50 copay
Specialist Visit	$0 after deductible	$0 after deductible	$100 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$50 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	$0 after deductible	$50 copay
Diagnostic Test — Lab Services	$0 after deductible	$0 after deductible	50% after deductible
Diagnostic Test — X-rays	$0 after deductible	$0 after deductible	50% after deductible
Urgent Care	$0 after deductible	$0 after deductible	$75 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$25 deductible does not apply/ $50 after deductible/ $100 after deductible/ $500 after deductible
Integrated Adult Dental and Vision Available	No	No	No

** This plan is HSA-eligible*

WV, cont.

Coverage Level	Bronze 3800	Standard Silver 6000	Silver 0	Premier Silver 0
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $3,800 Family: $7,600	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $9,900 Family: $19,800	Individual: $8,900 Family: $17,800	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400
Primary Care Visit	$65 copay	$40 copay	$50 copay	$45 copay
Specialist Visit	$65 copay	$80 copay	$50 copay	$45 copay
Outpatient Mental Health and Substance Abuse Visits	$65 copay	$40 copay	$50 copay	$45 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$65 copay	$40 copay	$50 copay	$45 copay
Diagnostic Test — Lab Services	$65 copay	40% after deductible	$60 copay	$60 copay
Diagnostic Test — X-rays	$180 copay	40% after deductible	$175 copay	$175 copay
Urgent Care	$100 copay	$60 copay	$100 copay	$90 copay
Emergency Services	50% after deductible	40% after deductible	$1,250 copay	$1,250 copay
Hospital Inpatient — including facility and professional	50% after deductible	40% after deductible	$2,500 copay	$2,500 copay
Pharmacy Summary	$15 deductible does not apply/ 50% after deductible/ 50% after deductible/ 50% after deductible	$20 deductible does not apply/ $40 deductible does not apply/ $80 after deductible/ $350 after deductible	$5/$30/$250/50%	$5/$30/$250/50%
Integrated Adult Dental and Vision Available	Yes	No	Yes	Yes

WV, cont.

Coverage Level	Standard Gold 2000*	Gold 1700 HSA	Gold 0	Premier Gold 0
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $2,000 Family: $4,000	Individual: $1,700 Family: $3,400	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,200 Family: $16,400	Individual: $7,100 Family: $14,200	Individual: $7,500 Family: $15,000	Individual: $7,000 Family: $14,000
Primary Care Visit	$30 copay	$15 copay after deductible	$20 copay	$15 copay
Specialist Visit	$60 copay	$15 copay after deductible	$20 copay	$15 copay
Outpatient Mental Health and Substance Abuse Visits	$30 copay	$15 copay after deductible	$20 copay	$15 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$30 copay	$15 copay after deductible	$20 copay	$15 copay
Diagnostic Test — Lab Services	25% after deductible	$15 copay after deductible	$35 copay	$55 copay
Diagnostic Test — X-rays	25% after deductible	$15 copay after deductible	$35 copay	$100 copay
Urgent Care	$45 copay	$30 copay after deductible	$40 copay	$30 copay
Emergency Services	25% after deductible	$250 copay after deductible	$400 copay	$350 copay
Hospital Inpatient — including facility and professional	25% after deductible	$450 copay after deductible	$725 copay	$525 copay
Pharmacy Summary	$15/$30/$60/$250	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible	$0/$30/$150/50%	$0/$25/$75/50%
Integrated Adult Dental and Vision Available	Yes	No	Yes	Yes

** This plan is HSA-eligible*

WV — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Silver 3000**	**Premier Silver 0**	**Standard Silver 700**	**Premier Silver 0**
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $700 Family: $1,400	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,400 Family: $14,800	Individual: $7,700 Family: $15,400	Individual: $3,300 Family: $6,600	Individual: $3,400 Family: $6,800
Primary Care Visit	$40 copay	$45 copay	$20 copay	$0 copay
Specialist Visit	$80 copay	$45 copay	$40 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$40 copay	$45 copay	$20 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$40 copay	$45 copay	$20 copay	$0 copay
Diagnostic Test — Lab Services	40% after deductible	$60 copay	30% after deductible	$60 copay
Diagnostic Test — X-rays	40% after deductible	$175 copay	30% after deductible	$90 copay
Urgent Care	$60 copay	$90 copay	$30 copay	$10 copay
Emergency Services	40% after deductible	$1,250 copay	30% after deductible	$500 copay
Hospital Inpatient — including facility and professional	40% after deductible	$2,500 copay	30% after deductible	$550 copay
Pharmacy Summary	$20 not subject to deductible/ $40 not subject to deductible/ $80 after deductible/ $350 after deductible	$5 / $30 / $250 / 50%	$10 not subject to deductible/ $20 not subject to deductible/ $60 after deductible/ $250 after deductible	$0 / $10 / $50 / 50%
Integrated Adult Dental and Vision Available	No	Yes	No	Yes

WV — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Standard Silver 0**	**Premier 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: $2,200 Family: $4,400	Individual: $1,250 Family: $2,500
Primary Care Visit	$0 copay	$0 copay
Specialist Visit	$10 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$0 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 copay	$0 copay
Diagnostic Test — Lab Services	25%	$0 copay
Diagnostic Test — X-rays	25%	$0 copay
Urgent Care	$5 copay	$5 copay
Emergency Services	25%	$125 copay
Hospital Inpatient — including facility and professional	25%	$175 copay
Pharmacy Summary	$0/$15/$50/$150	$0/$1/$5/50%
Integrated Adult Dental and Vision Available	No	Yes

DE

my Blue Access Select PPO

DE, cont.

Coverage Level	Major Events 10600*	Bronze 9200*	Standard Bronze 7500*
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $7,500 Family: $15,000
In-Network Out-of-Pocket Maximum	Individual: $10,600 Family: $21,200	Individual: $9,200 Family: $18,400	Individual: $10,000 Family: $20,000
Primary Care Visit	First 3 visits free, then $0 after deductible	$0 after deductible	$50 copay
Specialist Visit	$0 after deductible	$0 after deductible	$100 copay
Outpatient Mental Health and Substance Abuse Visits	$0 after deductible	$0 after deductible	$50 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 after deductible	$0 after deductible	$23 copay
Chiropractic Care	$0 after deductible	$0 after deductible	25% after deductible
Diagnostic Test — Lab Services	$0 after deductible	$0 after deductible	50% after deductible
Diagnostic Test — X-rays	$0 after deductible	$0 after deductible	50% after deductible
Urgent Care	$0 after deductible	$0 after deductible	$75 copay
Emergency Services	$0 after deductible	$0 after deductible	50% after deductible
Hospital Inpatient — including facility and professional	$0 after deductible	$0 after deductible	50% after deductible
Pharmacy Summary	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$0 after deductible/ $0 after deductible/ $0 after deductible/ $0 after deductible	$25 not subject to deductible/ $50 after deductible/ $100 after deductible/ $150 after deductible
Integrated Adult Dental and Vision Available	No	No	No

** This plan is HSA-eligible*

DE, cont.

Coverage Level	Bronze 3800*	Standard Silver 6000	Silver 0**	Premier Silver 0***
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $3,800 Family: $7,600	Individual: $6,000 Family: $12,000	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $9,900 Family: $19,800	Individual: $8,900 Family: $17,800	Individual: $9,400 Family: $18,800	Individual: $9,700 Family: $19,400
Primary Care Visit	$70 copay	$40 copay	$50 copay	$45 copay
Specialist Visit	$70 copay	$80 copay	$50 copay	$45 copay
Outpatient Mental Health and Substance Abuse Visits	$70 copay	$40 copay	$50 copay	$45 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$23 copay	$23 copay	$23 copay	$23 copay
Chiropractic Care	25% after deductible	25% after deductible	25%	25%
Diagnostic Test — Lab Services	$65 copay	40% after deductible	$60 copay	$60 copay
Diagnostic Test — X-rays	$180 copay	40% after deductible	$185 copay	$185 copay
Urgent Care	$100 copay	$60 copay	$100 copay	$90 copay
Emergency Services	50% after deductible	40% after deductible	$1,250 copay	$1,250 copay
Hospital Inpatient — including facility and professional	50% after deductible	40% after deductible	$2,500 copay	$2,500 copay
Pharmacy Summary	$15 not subject to deductible/ 50% after deductible/ 50% after deductible/ 50% after deductible	$20 not subject to deductible/ $40 not subject to deductible/ $80 after deductible/ $125 after deductible	$5/$30/$250/50%	$5/$30/$250/50%
Integrated Adult Dental and Vision Available	Yes	No	Yes	Yes***

** This plan is HSA-eligible*
*** Off-Exchange only*
**** This plan is only available with included Adult Dental and Vision coverage.*

DE, cont.

Coverage Level	Standard Gold 2000	Gold 1700 HSA	Gold 0
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $2,000 Family: $4,000	Individual: $1,700 Family: $3,400	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $8,300 Family: $16,600	Individual: $7,100 Family: 14,200	Individual: $7,500 Family: $15,000
Primary Care Visit	$30 copay	$15 copay after deductible	$20 copay
Specialist Visit	$60 copay	$15 copay after deductible	$20 copay
Outpatient Mental Health and Substance Abuse Visits	$30 copay	$15 copay after deductible	$20 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$23 copay	$15 copay after deductible	$20 copay
Chiropractic Care	25% after deductible	20% after deductible	25%
Diagnostic Test — Lab Services	25% after deductible	$15 copay after deductible	$35 copay
Diagnostic Test — X-rays	25% after deductible	$15 copay after deductible	$35 copay
Urgent Care	$45 copay	$30 copay after deductible	$40 copay
Emergency Services	25% after deductible	$250 copay after deductible	$400 copay
Hospital Inpatient — including facility and professional	25% after deductible	$450 copay after deductible	$725 copay
Pharmacy Summary	$15/$30/$60/$100	$0 after deductible/ $30 after deductible/ $150 after deductible/ 50% after deductible	$0/$30/$150/50%
Integrated Adult Dental and Vision Available	Yes	No	Yes

DE, cont.

Coverage Level	Premier Gold 0***	Standard Platinum 0	Premier Platinum 0***
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,000 Family: $14,000	Individual: $5,300 Family: $10,600	Individual: $5,000 Family: $10,000
Primary Care Visit	$15 copay	$10 copay	$0 copay
Specialist Visit	$15 copay	$20 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$15 copay	$10 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$15 copay	$10 copay	$0 copay
Chiropractic Care	20%	$0	10%
Diagnostic Test — Lab Services	$55 copay	$30 copay	$0 copay
Diagnostic Test — X-rays	$100 copay	$30 copay	$0 copay
Urgent Care	$30 copay	$15 copay	$5 copay
Emergency Services	$350 copay	$100 copay	$100 copay
Hospital Inpatient — including facility and professional	$525 copay	$350 copay	$325 copay
Pharmacy Summary	$0/$25/$75/50%	$5/$10/$50/$75	$0/$10/$50/50%
Integrated Adult Dental and Vision Available	Yes***	No	Yes***

**** This plan is only available with included Adult Dental and Vision coverage.*

DE — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Standard Silver 3000**	**Premier Silver 0***	**Standard Silver 700**	**Premier Silver 0***
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $3,000 Family: $6,000	Individual: $0 Family: $0	Individual: $700 Family: $1,400	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $7,400 Family: $14,800	Individual: $7,850 Family: $15,700	Individual: $3,300 Family: $6,600	Individual: $3,400 Family: $6,800
Primary Care Visit	$40 copay	$45 copay	$20 copay	$0 copay
Specialist Visit	$80 copay	$45 copay	$40 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$40 copay	$45 copay	$20 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$23 copay	$23 copay	$20 copay	$0 copay
Chiropractic Care	25% after deductible	25%	25% after deductible	10%
Diagnostic Test — Lab Services	40% after deductible	$60 copay	30% after deductible	$60 copay
Diagnostic Test — X-rays	40% after deductible	$185 copay	30% after deductible	$90 copay
Urgent Care	$60 copay	$90 copay	$30 copay	$10 copay
Emergency Services	40% after deductible	$1,250 copay	30% after deductible	$500 copay
Hospital Inpatient — including facility and professional	40% after deductible	$2,500 copay	30% after deductible	$550 copay
Pharmacy Summary	$20 not subject to deductible/ $40 not subject to deductible/ $80 after deductible/ $125 after deductible	$5/$30/$250/50%	$10 not subject to deductible/ $20 not subject to deductible/ $60 after deductible/ $100 after deductible	$0/$10/$50/50%
Integrated Adult Dental and Vision Option	No	Yes*	No	Yes*

** This plan is only available with included Adult Dental and Vision coverage.*

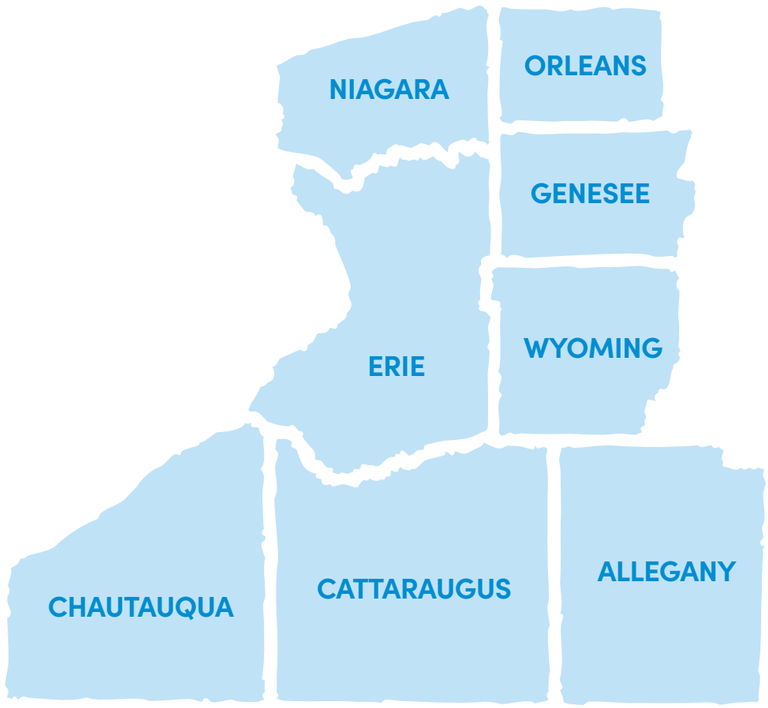
DE — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Standard Silver 0**	**Premier Silver 0***
Plan Availability	my Blue Access Select PPO	my Blue Access Select PPO
In-Network Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $2,400 Family: $4,800	Individual: $1,250 Family: $2,500
Primary Care Visit	$0 copay	$0 copay
Specialist Visit	$10 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$0 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$0 copay	$0 copay
Chiropractic Care	25%	10%
Diagnostic Test — Lab Services	25%	$0 copay
Diagnostic Test — X-rays	25%	$0 copay
Urgent Care	$5 copay	$5 copay
Emergency Services	25%	$125 copay
Hospital Inpatient — including facility and professional	25%	$175 copay
Pharmacy Summary	$0/$5/$10/$20	$0/$1/$5/50%
Integrated Adult Dental and Vision Option	No	Yes*

** This plan is only available with included Adult Dental and Vision coverage.*

WNY

my Blue Access EX



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: $4,125 Family: $8,250	Individual: $3,800 Family: $7,600	Individual: $2,450 Family: $4,900	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $10,150 Family: $20,300	Individual: $10,100 Family: $20,200	Individual: $10,150 Family: $20,300	Individual: $9,700 Family: $19,400
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 and Substance Abuse Visits	$50 copay after deductible	$75 copay	$30 copay after deductible	$0 copay
Speech, Physical, Occupational, and Chiropractic Care 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 Services	$50 copay after deductible	$75 copay	$50 copay after deductible	$50 copay
Diagnostic Test — X-rays	$75 copay after deductible	50% after deductible	$75 copay after deductible	$200 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 — including facility and professional	$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 not subject to deductible/ 50% after deductible/ 50% after deductible	$15/$40/$75	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

** This plan is HSA-eligible*

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: $775 Family: $1,550	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $10,150 Family: $20,300	Individual: $7,900 Family: $15,800	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 and Substance Abuse Visits	$25 copay after deductible	$0 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care 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 Services	$40 copay after deductible	$20 copay	$35 copay	$0 copay
Diagnostic Test — X-rays	$40 copay after deductible	50%	$35 copay	10%
Urgent Care	$60 copay after deductible	$60 copay	$55 copay	$0 copay
Emergency Services	$150 copay after deductible	$400 copay	$100 copay	$100 copay
Hospital Inpatient — including facility and professional	$1,000 copay after deductible	$725 copay	$500 copay	$275 copay
Pharmacy Summary	$10/$35/$70	$5/$50/50%	$10/$30/$60	$5/$30/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

WNY — Extra Savings

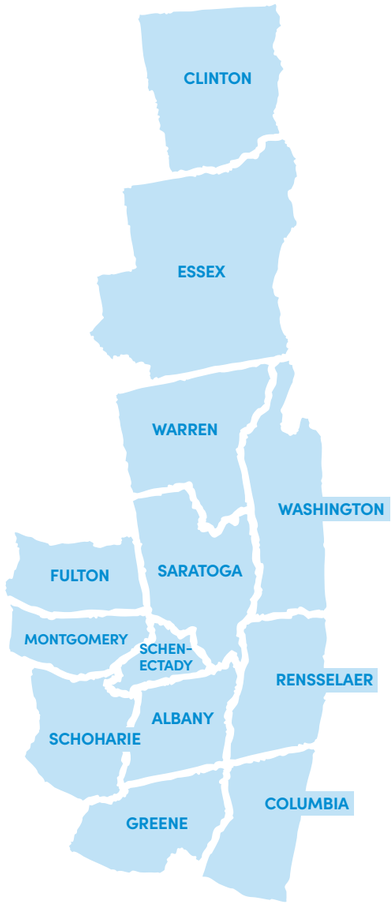
Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Standard Extra Savings Silver Enhanced**	**Destination 65 Extra Savings Silver Enhanced**	**Standard Extra Savings Silver Supreme**	**Destination 65 Extra Savings Silver Supreme**
Network Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: $2,160 Family: $4,320	Individual: $0 Family: $0	Individual: $450 Family: $900	Individual: $0 Family: $0
In-Network out-of-pocket Maximum	Individual: $8,100 Family: $16,200	Individual: $8,100 Family: $16,200	Individual: $3,350 Family: $6,700	Individual: $3,100 Family: $6,200
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 and Substance Abuse Visits	$30 copay after deductible	$0 copay	$15 copay after deductible	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$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 Services	$50 copay after deductible	$50 copay	$35 copay after deductible	$0 copay
Diagnostic Test — X-rays	$75 copay after deductible	$200 copay	$35 copay after deductible	$100 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	$15/50%/50%	$9/$20/$40	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

WNY — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Standard Extra Savings Silver C**	**Destination 65 Extra Savings Silver C**
Network 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: $1,275 Family: $2,550	Individual: $900 Family: $1,800
Primary Care Visit	$10 copay	$0 copay
Specialist Visit	$20 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$10 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$15 copay	$0 copay
Chiropractic Care	$20 copay	$0 copay
Diagnostic Test — Lab Services	$20 copay	$0 copay
Diagnostic Test — X-rays	$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	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes

NENY

my Blue Access EX



NENY, cont.

Coverage Level	Bronze Standard*	Bronze Destination 65*	Silver Standard	Silver Destination 65
Plan Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: $4,125 Family: $8,250	Individual: $3,800 Family: $7,600	Individual: $2,450 Family: $4,900	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $10,150 Family: $20,300	Individual: $10,100 Family: $20,200	Individual: $10,150 Family: $20,300	Individual: $9,700 Family: $19,400
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 and Substance Abuse Visits	$50 copay after deductible	$75 copay	$30 copay after deductible	$0 copay
Speech, Physical, Occupational, and Chiropractic Care 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 Services	$50 copay after deductible	$75 copay	$50 copay after deductible	$50 copay
Diagnostic Test — X-rays	$75 copay after deductible	50% after deductible	$75 copay after deductible	$200 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 — including facility and professional	$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 not subject to deductible/ 50% after deductible/ 50% after deductible	$15/$40/$75	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

** This plan is HSA-eligible*

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: $775 Family: $1,550	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $0 Family: $0
In-Network Out-of-Pocket Maximum	Individual: $10,150 Family: $20,300	Individual: $7,900 Family: $15,800	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 and Substance Abuse Visits	$25 copay after deductible	$0 copay	$15 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care 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 Services	$40 copay after deductible	$20 copay	$35 copay	$0 copay
Diagnostic Test — X-rays	$40 copay after deductible	50%	$35 copay	10%
Urgent Care	$60 copay after deductible	$60 copay	$55 copay	$0 copay
Emergency Services	$150 copay after deductible	$400 copay	$100 copay	$100 copay
Hospital Inpatient — including facility and professional	$1,000 copay after deductible	$725 copay	$500 copay	$275 copay
Pharmacy Summary	$10/$35/$70	$5/$50/50%	$10/$30/$60	$5/$30/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

NENY — Extra Savings

Income Level	200% – 249% FPL		150% – 199% FPL	
Coverage Level	**Standard Extra Savings Silver Enhanced**	**Destination 65 Extra Savings Silver Enhanced**	**Standard Extra Savings Silver Supreme**	**Destination 65 Extra Savings Silver Supreme**
Network Availability	my Blue Access EX	my Blue Access EX	my Blue Access EX	my Blue Access EX
In-Network Deductible	Individual: $2,160 Family: $4,320	Individual: $0 Family: $0	Individual: $450 Family: $900	Individual: $0 Family: $0
In-Network out-of-pocket Maximum	Individual: $8,100 Family: $16,200	Individual: $8,100 Family: $16,200	Individual: $3,350 Family: $6,700	Individual: $3,100 Family: $6,200
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 and Substance Abuse Visits	$30 copay after deductible	$0 copay	$15 copay after deductible	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$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 Services	$50 copay after deductible	$50 copay	$35 copay after deductible	$0 copay
Diagnostic Test — X-rays	$75 copay after deductible	$200 copay	$35 copay after deductible	$100 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	$15/50%/50%	$9/$20/$40	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes	No	Yes

NENY — Extra Savings

Income Level	138% – 149% FPL	
Coverage Level	**Standard Extra Savings Silver C**	**Destination 65 Extra Savings Silver C**
Network 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: $1,275 Family: $2,550	Individual: $900 Family: $1,800
Primary Care Visit	$10 copay	$0 copay
Specialist Visit	$20 copay	$0 copay
Outpatient Mental Health and Substance Abuse Visits	$10 copay	$0 copay
Speech, Physical, Occupational, and Chiropractic Care Therapy	$15 copay	$0 copay
Chiropractic Care	$20 copay	$0 copay
Diagnostic Test — Lab Services	$20 copay	$0 copay
Diagnostic Test — X-rays	$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	$15/50%/50%
Integrated Adult Dental and Vision Option	No	Yes

Products Overview

Together Blue EPO

Available in western Pennsylvania — Allegheny, Butler, Erie, Washington, and Westmoreland counties. The most affordable product option in western Pennsylvania, Together Blue EPO includes:

- Access to world-class care close to home from Allegheny Health Network (AHN) and select independent providers.

Please visit **ahn.org/locations** for more information on AHN and expansion updates.

my Direct Blue EPO

Available in 24 counties across western and central Pennsylvania. The most affordable product option in central Pennsylvania, my Direct Blue EPO includes:

- Community providers and hospitals that are participating with Highmark to deliver high-quality, lower-cost care.
- In-network access to national BlueCard® providers outside of western and central Pennsylvania for routine care.
- Plans that are available on- and off-exchange.

my Blue Access PPO

Available in 54 counties across western, central, and southeastern Pennsylvania, my Blue Access includes:

- Comprehensive, in-network access throughout western, central, and southeastern Pennsylvania — including all AHN and UPMC hospitals and hospitals in central Pennsylvania and the Lehigh Valley.
- In-network access to national BlueCard® providers outside of western, central, and southeastern Pennsylvania for routine care.
- Plans that are available on- and off-exchange in western, central, and southeastern Pennsylvania.
- The ability for members to select any provider of their choice, with benefits available in and out of network.
- Select plans in the five-county southeastern region will allow members to save on labs, X-rays, and imaging when using free-standing facilities ("Member Savings Sites") rather than utilizing hospital-based facilities. Member Savings Sites, or facilities where members can take advantage of the lower cost sharing, will be clearly identified in the online directory.

my Priority Blue Flex PPO

Available in all 13 northeastern Pennsylvania counties, my Priority Blue Flex includes:

- In-network care offered at both the Enhanced and Standard levels of benefits, with lower out-of-pocket costs when receiving care from Enhanced providers.
- Standard level of benefits to my Direct Blue's ACA Select network providers in western and central Pennsylvania as well as BlueCard® providers outside of western, central, and northeastern Pennsylvania — including the Philadelphia region.
- Plans that are available on- and off-exchange.

my Blue Access Select PPO

my Blue Access Select PPO plans provide in-network access to a statewide network of high-quality, cost-effective care in Delaware as well as Maryland, New Jersey, and Pennsylvania. Members are able to select any in-network provider or facility of their choice. As part of our broadest network, these plans include in-network access to BlueCard® providers outside of Delaware as well as facilities like ChristianaCare, Bayhealth, Beebe Medical Center, and Nemours/ Alfred I. duPont Hospital for Children. Available in all three Delaware counties.

my Blue Access WV PPO

my Blue Access WV plans provide in-network access to a statewide network of high-quality, cost-effective care in West Virginia as well as Kentucky, Maryland, Ohio, Pennsylvania, and Virginia. Members are able to select any in-network provider or facility of their choice. As part of our broadest network, these plans include in-network access to BlueCard® providers outside of West Virginia. Available in all 55 West Virginia counties.

New York

my Blue Access EX plans are available in all 8 counties in Western New York and all 13 counties in Northeastern New York and provide in-network access to our broadest local network in New York, plus in-network access to providers in the national BlueCard® network.

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 care plan and get recommended resources for 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, primary care, 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 members as a part of their medical benefits.

Features 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.
- Prescriptions, if needed, will be sent to the member's pharmacy of choice for pickup.

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

Highmark's Virtual Physical Care Program Powered by Sword

Virtual Physical Care powered by Sword provides a clinical-grade digital musculoskeletal (MSK) care platform paired with expert physical therapists and technology to deliver a personalized exercise plan. Key components of the program include:

- Licensed physical therapists, delivering 100% of the human aspect of the program through virtual technology.
- Technology that gives real-time feedback that's more accurate than human eyes.
- Plans for all the major joints — lower back, shoulder, neck, knee, elbow, hip, ankle, and wrist.
- A program that can accommodate all phases of the pain spectrum: acute, chronic, pre-surgery, and post-surgery rehab.
- A preventive program that addresses low-level musculoskeletal care needs.

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.

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

ACA Individual Market Pharmacy Network

	In Network	OON
PA	Costco Wholesale, CVS pharmacy, sam's club, GIANT, giant eagle, Target, Sav-on Pharmacy, Walmart, The Medicine Shoppe Pharmacy, weis Select Specialty Pharmacies Select Independent Pharmacies	Walgreens
WV	CVS pharmacy, sam's club, The Medicine Shoppe Pharmacy, Walgreens, Target, Walmart Select Specialty Pharmacies Select Independent Pharmacies	
DE	CVS pharmacy, sam's club, Walmart, Walgreens, Target Select Specialty Pharmacies Select Independent Pharmacies	
NY	Costco Wholesale, Target, Price Chopper, Tops, Walgreens, Wegmans, The Medicine Shoppe Pharmacy, sam's club, KinneyDrugs Experience the Difference., CVS pharmacy, Walmart, STOP&SHOP Select Specialty Pharmacies Select Independent Pharmacies	

Changes to our pharmacy network may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

ACA Individual Market In-Network Hospitals

Pennsylvania — Together Blue EPO

Facility Name	County
AHN Allegheny General Hospital	Allegheny
AHN Allegheny Valley Hospital	
AHN Brentwood Neighborhood Hospital	
AHN Forbes Hospital	
AHN Harmar Neighborhood Hospital	
AHN Jefferson Hospital	
AHN McCandless Neighborhood Hospital	
AHN West Penn Hospital	
AHN Wexford Hospital	
UPMC Children's Hospital of Pittsburgh	
UPMC Western Psychiatric Hospital	
UPMC Bedford	Bedford
UPMC Altoona	Blair
AHN Westfield Memorial Hospital	Chautauqua (New York)
AHN Saint Vincent Hospital	Erie
UPMC Jameson	Lawrence
UPMC Kane	McKean
AHN Grove City	Mercer
UPMC Horizon — Greenville	
UPMC Horizon — Shenango Valley	
UPMC Cole	Potter
UPMC Somerset Hospital	Somerset
UPMC Northwest	Venango
AHN Canonsburg Hospital	Washington
AHN Hempfield Neighborhood Hospital	Westmoreland

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

ACA Individual Market In-Network Hospitals

Pennsylvania — my Direct Blue EPO

Facility Name	County
WellSpan Gettysburg Hospital	Adams
AHN Allegheny General Hospital	Allegheny
AHN Allegheny Valley Hospital	
AHN Brentwood Neighborhood Hospital	
AHN Forbes Hospital	
AHN Harmar Neighborhood Hospital	
AHN Jefferson Hospital	
AHN McCandless Neighborhood Hospital	
AHN West Penn Hospital	
AHN Wexford Hospital	
Heritage Valley Sewickley	
St. Clair Hospital	
UPMC Children's Hospital of Pittsburgh	
UPMC Western Psychiatric Hospital	
Armstrong County Memorial Hospital	Armstrong
Heritage Valley Beaver	Beaver
UPMC Bedford	Bedford
Penn State Health St. Joseph Medical Center	Berks
Surgical Institute of Reading	
Conemaugh Nason Medical Center	Blair
Penn Highlands Tyrone	
UPMC Altoona	
Guthrie Robert Packer Hospital	Bradford
Guthrie Towanda Memorial Hospital	
Guthrie Troy Community Hospital	
Doylestown Hospital	Bucks
Grand View Hospital	
Jefferson Health — Bucks Hospital	
St. Mary Medical Center	
BHS Butler Memorial Hospital	Butler
Conemaugh Memorial Medical Center	Cambria
Conemaugh Memorial Medical Center — Lee Campus	
Conemaugh Miners Medical Center	
Lehigh Valley Hospital — Carbon	Carbon
St. Luke's Hospital — Carbon Campus	
St. Luke's Hospital — Leighton Campus	
Mount Nittany Medical Center	Centre
Main Line Health — Paoli Hospital	Chester
Penn Medicine — Chester County Hospital	
Tower Health — Phoenixville Hospital	
BHS Clarion Hospital	Clarion
Penn Highlands Clearfield	Clearfield
Penn Highlands DuBois	
Bucktail Medical Center	Clinton
UPMC Lock Haven	

Facility Name	County
Meadville Medical Center	Crawford
Titusville Area Hospital	
Penn State Health Hampden Medical Center	Cumberland
Penn State Health Holy Spirit Medical Center	
UPMC Carlisle	
Penn State Health Children's Hospital — Milton S. Hershey Medical Center	Dauphin
Penn State Health Milton S. Hershey Medical Center	
Crozer Health — Delaware County Memorial Hospital	Delaware
Crozer Health — Springfield Hospital	
Main Line Health — Bryn Mawr Hospital	
Main Line Health — Riddle Hospital	
Trinity Health — Mercy Fitzgerald Hospital	
Penn Highlands Elk	Elk
AHN Saint Vincent Hospital	Erie
LECOM Health — Corry Memorial Hospital	
LECOM Health — Millcreek Community Hospital	
Select Specialty Hospital – Erie	
Penn Highlands Connellsville	Fayette
WVU Medicine — Uniontown Hospital	
WellSpan Chambersburg Hospital	Franklin
WellSpan Waynesboro Hospital	
UPMC Greene	Greene
Penn Highlands Huntingdon	Huntingdon
Indiana at Chestnut Ridge	Indiana
Indiana Regional Medical Center	
Penn Highlands Brookville	Jefferson
Punxsutawney Area Hospital	
CHS Moses Taylor Hospital	Lackawanna
CHS Regional Hospital of Scranton	
Geisinger Community Medical Center	
Lehigh Valley Hospital — Dickson City	
Lancaster General Hospital	Lancaster
Lancaster General Hospital Women and Babies	
Penn State Health Lancaster Medical Center	
WellSpan Ephrata Community Hospital	
UPMC Jameson	Lawrence
WellSpan Good Samaritan Hospital	Lebanon
Lehigh Valley Hospital — 17th Street	Lehigh
Lehigh Valley Hospital — Cedar Crest	
Lehigh Valley Hospital — Macungie	
Lehigh Valley Hospital — Muhlenberg	
Lehigh Valley Cedar Crest — Reilly Children's Hospital	
CHS Wilkes-Barre General Hospital	Luzerne
Geisinger Wyoming Valley Medical Center	
Lehigh Valley Hospital — Hazleton	

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

ACA Individual Market In-Network Hospitals

Pennsylvania — my Direct Blue EPO, cont.

Facility Name	County
Geisinger Jersey Shore Hospital	Lycoming
Geisinger Medical Center Muncy	
UPMC Muncy	
Geisinger Medical Center Muncy	
UPMC Williamsport	
UPMC Williamsport Divine Providence	
Bradford Regional Medical Center	McKean
UPMC Kane	
AHN Grove City	Mercer
Edgewood Surgical Hospital	
Sharon Regional Medical Center	
UPMC Horizon — Greenville	
UPMC Horizon — Shenango Valley	
Lehigh Valley Hospital — Pocono	Monroe
St. Luke's Hospital — Monroe Campus	
Einstein Medical Center Elkins Park	Montgomery
Einstein Medical Center Montgomery	
Holy Redeemer Hospital	
Jefferson Health — Abington Hospital	
Jefferson Health — Abington Lansdale Hospital	
Lehigh Valley Hospital — Gilbertsville	
Main Line Health — Bryn Mawr Hospital	
Main Line Health — Lankenau Medical Center	
Physicians Care Surgical Hospital LP	
Pottstown Hospital	
Lehigh Valley Hospital – Hecktown Oaks	Northampton
Children's Hospital of Philadelphia	Philadelphia
Einstein Medical Center Philadelphia	
Jefferson Health — Frankford Hospital	
Jefferson Health — Methodist Hospital	
Jefferson Health — Thomas Jefferson University Hospital	
Jefferson Health — Torresdale Hospital	
Jefferson Health — Wills Eye Hospital	
Nazareth Hospital	
Penn Medicine — Hospital of the University of Pennsylvania	
Penn Medicine — Penn Presbyterian Medical Center	
Penn Medicine — Pennsylvania Hospital	
Roxborough Memorial Hospital	
St Christopher's Hospital for Children	
Temple Health — Chestnut Hill Hospital	
Temple Health — Fox Chase Cancer Center	
Temple Health — Temple University Hospital	
Temple University Hospital — Episcopal Campus	
Temple University Hospital — Jeanes Campus	
Temple University Hospital — Northeastern Campus	
Wills Eye Hospital	
UPMC Cole	Potter

Facility Name	County
Geisinger St. Luke's Hospital	Schuylkill
Lehigh Valley Hospital — Schuylkill E. Norwegian Street	
Lehigh Valley Hospital — Schuylkill S. Jackson Street	
Chan Soon-Shiong Medical Center at Windber	Somerset
Conemaugh Meyersdale Medical Center	
UPMC Somerset	
Barnes-Kasson Hospital	Susquehanna
Endless Mountains Health Systems	
UPMC Wellsboro	Tioga
Wellspan Evangelical Community Hospital	Union
UPMC Northwest	Venango
Warren General Hospital	Warren
Advanced Surgical Hospital	Washington
AHN Canonsburg Hospital	
Monongahela Valley Hospital	
UPMC Washington Hospital	
Wayne Memorial Hospital	Wayne
AHN Hempfield Neighborhood Hospital	Westmoreland
Excela Health Frick Hospital	
Excela Health Latrobe Hospital	
Excela Health Westmoreland Hospital	
WellSpan York Hospital	York
WellSpan Surgery and Rehabilitation Hospital	

Out-of-state providers

Facility Name	State
Meritus Medical Center	MD
The Johns Hopkins Hospital	
University of Maryland Medical Center	
UPMC Western Maryland	
WVU Medicine — Garrett Regional Medical Center	
AHN Westfield Memorial Hospital	NY
Guthrie Corning Hospital	
Olean General Hospital	
UR Medicine — Jones Memorial Hospital	
UR Medicine — Strong Memorial Hospital	
Cleveland Clinic	OH
WVU Medicine — Children's Hospital	WV
WVU Medicine — J.W. Ruby Memorial Hospital	

The out-of-state hospitals above will be processed at in-network benefit level due to their participation in the BlueCard PPO network.

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

ACA Individual Market In-Network Hospitals

Pennsylvania — my Blue Access PPO

Facility Name	County
WellSpan Gettysburg Hospital	Adams
AHN Allegheny General Hospital	Allegheny
AHN Allegheny Valley Hospital	
AHN Brentwood Neighborhood Hospital	
AHN Forbes Hospital	
AHN Harmar Neighborhood Hospital	
AHN Jefferson Hospital	
AHN McCandless Neighborhood Hospital	
AHN West Penn Hospital	
AHN Wexford Hospital	
Curahealth Pittsburgh	
Heritage Valley Kennedy	
Heritage Valley Sewickley	
Select Specialty Hospital — McKeesport	
Select Specialty Hospital — Pittsburgh UPMC	
St. Clair Hospital	
UPMC Children's Hospital of Pittsburgh	
UPMC East	
UPMC Magee-Womens Hospital	
UPMC McKeesport	
UPMC Mercy	
UPMC Vision and Rehabilitation Tower	
UPMC Passavant — McCandless	
UPMC Presbyterian	
UPMC Shadyside	
UPMC St. Margaret	
UPMC Western Psychiatric Hospital	
Armstrong County Memorial Hospital	Armstrong
Curahealth Hospital Heritage Valley	Beaver
Heritage Valley Beaver	
UPMC Bedford	Bedford
Penn State Health St. Joseph Medical Center	Berks
Surgical Institute of Reading	
Reading Hospital — Tower Health	
Conemaugh Nason Medical Center	Blair
Penn Highlands Tyrone	
UPMC Altoona	
Guthrie Robert Packer Hospital	Bradford
Guthrie Towanda Memorial Hospital	
Guthrie Troy Community Hospital	

Facility Name	County
Doylestown Hospital	Bucks
Grand View Health	
Jefferson Health — Bucks Hospital	
Lower Bucks Hospital	
Rothman Orthopaedic Specialty Hospital	
St. Luke's Hospital — Upper Bucks Campus	
St. Mary Medical Center	
BHS Butler Memorial Hospital	Butler
UPMC Passavant — Cranberry	
Conemaugh Memorial Medical Center	Cambria
Conemaugh Memorial Medical Center — Lee Campus	
Conemaugh Miners Medical Center	
Lehigh Valley Hospital — Carbon	Carbon
St. Luke's Hospital — Carbon Campus	
St. Luke's Hospital — Leighton Campus	
Mount Nittany Medical Center	Centre
Main Line Health — Paoli Hospital	Chester
Penn Medicine — Chester County Hospital	
Tower Health — Phoenixville Hospital	
BHS Clarion Hospital	Clarion
Penn Highlands Clearfield	Clearfield
Penn Highlands DuBois	
Bucktail Medical Center	Clinton
UPMC Lock Haven	
Geisinger Bloomsburg Hospital	Columbia
Meadville Medical Center	Crawford
Titusville Area Hospital	
Penn State Health Hampden Medical Center	Cumberland
Penn State Health Holy Spirit Medical Center	
UPMC Carlisle	
UPMC West Shore	
Penn State Health Children's Hospital	Dauphin
Penn State Health Milton S. Hershey Medical Center	
UPMC Community Osteopathic	
UPMC Harrisburg	
Crozer Health — Delaware County Memorial Hospital	Delaware
Crozer Health — Springfield Hospital	
Main Line Health — Bryn Mawr Hospital	
Main Line Health — Riddle Hospital	
Trinity Health — Mercy Fitzgerald Hospital	
Penn Highlands Elk	Elk
AHN Saint Vincent Hospital	Erie
LECOM Health — Corry Memorial Hospital	
LECOM Health — Millcreek Community Hospital	
UPMC Hamot	

Changes to our in-network facilities may occur during the benefit year. Any changes made after the production date of this guide will be included with our product benefit grid and map reference guide.

ACA Individual Market In-Network Hospitals

Pennsylvania — my Blue Access PPO, cont.

Facility Name	County
Penn Highlands Connellsville	Fayette
WVU Medicine — Uniontown Hospital	
WellSpan Chambersburg Hospital	Franklin
WellSpan Waynesboro Hospital	
Fulton County Medical Center	Fulton
UPMC Greene	Greene
Penn Highlands Huntingdon	Huntingdon
Indiana Regional Medical Center	Indiana
Penn Highlands Brookville	Jefferson
Punxsutawney Area Hospital	
CHS Moses Taylor Hospital	Lackawanna
CHS Regional Hospital of Scranton	
Geisinger Community Medical Center	
Lancaster General Hospital	Lancaster
Lancaster General Hospital Women and Babies	
Penn State Health Lancaster Medical Center	
UPMC Lititz	
WellSpan Ephrata Community Hospital	
UPMC Jameson	Lawrence
WellSpan Good Samaritan Hospital	Lebanon
Lehigh Valley Hospital — 17th Street	Lehigh
Lehigh Valley Hospital — Cedar Crest	
Lehigh Valley Hospital — Muhlenberg	
Lehigh Valley Hospital —Macungie	
Lehigh Valley Reilly Children's Hospital	
St. Luke's Hospital — Allentown Campus	
St. Luke's Hospital — Sacred Heart Campus	
CHS Wilkes-Barre General Hospital	Luzerne
Geisinger Wyoming Valley Medical Center	
Lehigh Valley Hospital — Hazleton	
Geisinger Jersey Shore Hospital	Lycoming
Geisinger Medical Center Muncy	
UPMC Muncy	
UPMC Williamsport	
UPMC Williamsport Divine Providence	
Bradford Regional Medical Center	McKean
UPMC Kane	
AHN Grove City Hospital	Mercer
Edgewood Surgical Hospital	
Sharon Regional Medical Center	
UPMC Horizon — Greenville	
UPMC Horizon — Shenango Valley	
Geisinger Lewistown Hospital	Mifflin

Facility Name	County
Lehigh Valley Hospital — Pocono	Monroe
St. Luke's Hospital — Monroe Campus	
Einstein Medical Center Elkins Park	Montgomery
Einstein Medical Center Montgomery	
Holy Redeemer Hospital	
Jefferson Health — Abington Hospital	
Jefferson Health — Abington Lansdale Hospital	
Lehigh Valley Hospital — Gilbertsville	
Main Line Health — Bryn Mawr Hospital	
Main Line Health — Lankenau Medical Center	
Physicians Care Surgical Hospital LP	
Pottstown Hospital	
Geisinger Janet Weis Children's Hospital	Montour
Geisinger Medical Center	
Lehigh Valley Hospital – Hecktown Oaks	Northampton
St. Luke's Hospital — Anderson Campus	
St. Luke's Hospital — Easton Campus	
St. Luke's University Hospital — Bethlehem	
Geisinger Shamokin Area Community Hospital	Northumberland
Children's Hospital of Philadelphia	Philadelphia
Einstein Medical Center Philadelphia	
Jefferson Health — Frankford Hospital	
Jefferson Health — Methodist Hospital	
Jefferson Health — Thomas Jefferson University Hospital	
Jefferson Health — Torresdale Hospital	
Jefferson Health — Wills Eye Hospital	
Nazareth Hospital	
Penn Medicine — Hospital of the University of Pennsylvania	
Penn Medicine — Penn Presbyterian Medical Center	
Penn Medicine — Pennsylvania Hospital	
Roxborough Memorial Hospital	
St Christopher's Hospital for Children	
Temple Health — Chestnut Hill Hospital	
Temple Health — Fox Chase Cancer Center	
Temple Health — Temple University Hospital	
Temple University Hospital — Episcopal Campus	
Temple University Hospital — Jeanes Campus	
Temple University Hospital — Northeastern Campus	
Wills Eye Hospital	
UPMC Cole	Potter
Geisinger St. Luke's Hospital	Schuylkill
Lehigh Valley Hospital — Schuylkill E. Norwegian Street	
Lehigh Valley Hospital — Schuylkill S. Jackson Street	
St. Luke's Hospital — Miners Campus	

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ACA Individual Market In-Network Hospitals

Pennsylvania — my Blue Access PPO, cont.

Facility Name	County
Chan Soon-Shiong Medical Center at Windber	Somerset
Conemaugh Meyersdale Medical Center	
UPMC Somerset	
Barnes-Kasson Hospital	Susquehanna
Endless Mountains Health Systems	
UPMC Wellsboro	Tioga
Evangelical Community Hospital	Union
UPMC Northwest	Venango
Warren General Hospital	Warren
Advanced Surgical Hospital	Washington
AHN Canonsburg Hospital	
Monongahela Valley Hospital	
Washington Hospital	
Wayne Memorial Hospital	Wayne
AHN Hempfield Neighborhood Hospital	Westmoreland
Excela Health Frick Hospital	
Excela Health Latrobe Hospital	
Excela Health Westmoreland Hospital	
OSS Orthopaedic Hospital	York
UPMC Hanover	
UPMC Memorial	
WellSpan Surgery and Rehabilitation Hospital	
WellSpan York Hospital	

Out-of-state providers

Facility Name	State
Meritus Medical Center	MD
The Johns Hopkins Hospital	
University of Maryland Medical Center	
UPMC Western Maryland	
WVU Medicine — Garrett Regional Medical Center	
AHN Westfield Memorial Hospital	NY
Guthrie Corning Hospital	
Olean General Hospital	
UR Medicine — Jones Memorial Hospital	
UR Medicine — Strong Memorial Hospital	
Cleveland Clinic	OH
WVU Medicine — Children's Hospital	WV
WVU Medicine — J.W. Ruby Memorial Hospital	

This is not a complete list of out-of-state providers. Refer to Provider Directory to look up specific facilities that may be in network via BlueCard.

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ACA Individual Market In-Network Hospitals

NEPA — myPriority Blue Flex

Facility Name	County
Robert Packer Hospital*	Bradford
Robert Packer Hospital — Towanda Campus*	
Troy Community Hospital*	
Lehigh Valley Hospital — Carbon*	Carbon
St Lukes Hospital Carbon Campus	
St Lukes Hospital Lehighton Campus	
Bucktail Medical Center	
Geisinger Community Med Ctr	Lackawanna
Lehigh Valley Hospital Dickson City*	
Regional Hospital of Scranton*	
Geisinger Wyoming Valley Medical Center	Luzerne
Lehigh Valley Hospital-Hazleton*	
Wilkes Barre General Hospital*	
Geisinger Jersey Shore Hospital	Lycoming
UPMC Muncy	
UPMC Williamsport	
Lehigh Valley Hospital — Pocono*	Monroe
St Lukes Hospital Monroe Campus	
Barnes Kasson County Hospital	Susquehanna
Endless Mountain Health System*	
UPMC Wellsboro	Tioga
Wayne Memorial Hospital*	Wayne

** In-Network Enhanced*

Out-of-state providers

Facility Name	State
Meritus Medical Center	MD
The Johns Hopkins Hospital	
University of Maryland Medical Center	
UPMC Western Maryland	
WVU Medicine — Garrett Regional Medical Center	
AHN Westfield Memorial Hospital	NY
Guthrie Corning Hospital	
Olean General Hospital	
UR Medicine — Jones Memorial Hospital	
UR Medicine — Strong Memorial Hospital	
Cleveland Clinic	OH
WVU Medicine — Children's Hospital	WV
WVU Medicine — J.W. Ruby Memorial Hospital	

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ACA Individual Market In-Network Hospitals

West Virginia — my Blue Access WV PPO

Facility Name	County
Broaddus Hospital	Barbour
WVU Medicine — Berkeley Medical Center	Berkeley
Boone Memorial Hospital	Boone
WVU Medicine — Braxton County Memorial Hospital	Braxton
Acuity Specialty Hospital of Ohio Valley — Weirton	Brooke
Weirton Medical Center	
Cabell Huntington Hospital	Cabell
St. Mary's Medical Center	
Minnie Hamilton Health Center	Calhoun
Montgomery General Hospital	Fayette
Plateau Medical Center	
Grant Memorial Hospital	Grant
CAMC Greenbrier Valley Medical Center	Greenbrier
Valley Health — Hampshire Memorial Hospital	Hampshire
Weirton Medical Center	Hancock
WVU Medicine — United Hospital Center	Harrison
WVU Medicine — Jackson General Hospital	Jackson
WVU Medicine — Jefferson Medical Center	Jefferson
CAMC Women and Children's hospital	Kanawha
CAMC General Hospital	
CAMC Memorial Hospital	
Thomas Memorial Hospital	
Stonewall Jackson Memorial Hospital	Lewis
Logan General Hospital	Logan
Mon Health Marion	Marion
WVU Medicine — Reynolds Memorial Hospital	Marshall
Rivers Health	Mason
Welch Community Hospital	McDowell
WVU Medicine — Princeton Community Hospital	Mercer
WVU Medicine — Potomac Valley Hospital	Mineral
Williamson Memorial	Mingo
Mon Health Medical Center	Monongalia
WVU Medicine — Chestnut Ridge Center	
WVU Medicine — Children's Hospital	
WVU Medicine — J.W. Ruby Memorial Hospital	
Valley Health — War Memorial Hospital	Morgan
WVU Medicine — Summersville Regional Medical Center	Nicholas
WVU Medicine — Wheeling Hospital	Ohio
Pocahontas Memorial Hospital	Pocahontas
Mon Health Preston Memorial Hospital	Preston
CAMC Teays Valley Hospital	Putnam
Beckley ARH Hospital	Raleigh
Raleigh General Hospital	

Facility Name	County
Davis Medical Center	Randolph
Roane General Hospital	Roane
Summers County ARH Hospital	Summers
Grafton City Hospital	Taylor
Sistersville General Hospital	Tyler
WVU Medicine — St. Joseph's Hospital	Upshur
Webster County Memorial Hospital	Webster
WVU Medicine — Wetzel County Hospital	Wetzel
WVU Medicine — Camden Clark Medical Center	Wood

Out-of-state providers

Facility Name	State
King's Daughters Medical Center	KY
Pikeville Medical Center	
Tug Valley ARH Regional Medical Center	
University of Kentucky HealthCare Hospitals	
Meritus Medical Center	MD
The Johns Hopkins Hospital	
University of Maryland Medical Center	
UPMC Western Maryland	
WVU Medicine — Garrett Regional Medical Center	
Cleveland Clinic	OH
East Liverpool City Hospital	
Holzer Medical Center — Gallipolis	
Holzer Medical Center — Jackson	
Marietta Memorial Hospital	
Mount Carmel New Albany Surgical Hospital	
Selby General Hospital	
Southern Ohio Medical Center	
The Ohio State University Wexner Medical Center	
Trinity Medical Center East	
Trinity Medical Center West	
WVU Medicine — Barnesville Hospital	
WVU Medicine — Harrison Community Hospital	

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ACA Individual Market In-Network Hospitals

Delaware — my Blue Access Select PPO

Facility Name	County
Bayhealth Hospital — Kent Campus	Kent
ChristianaCare — Christiana Hospital	New Castle
ChristianaCare — Wilmington Hospital	
Delaware Psychiatric Center	
Nemours Children's Hospital	
Saint Francis Hospital	
Bayhealth Hospital — Sussex Campus	Sussex
Beebe Medical Center	
TidalHealth — Nanticoke Hospital	

Out-of-state providers

Facilty Name	State
The Johns Hopkins Hospital	MD
TidalHealth — Peninsula Regional Medical Center	
Memorial Sloan Kettering Cancer Center — Basking Ridge	NJ
Children's Hospital of Philadelphia	PA
Einstein Medical Center Philadelphia	
Penn Medicine — Hospital of the University of Pennsylvania	
Penn Medicine — Pennsylvania Hospital	

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ACA Individual Market In-Network Hospitals

Northeastern New York

Facility Name	County
Albany Medical Center Hospital	Albany
Albany Medical Center South Clinical Campus	
Samaritan Hospital — Albany Memorial Campus	
St. Peter's Hospital	
Champlain Valley Physicians Hospital	Clinton
Columbia Memorial Hospital	Columbia
Vassar Brothers Hospital	Dutchess
Elizabethtown Community Hospital	Essex
Elizabethtown Community Hospital — Moses Ludington Campus	
Adirondack Medical Center	Franklin
Alice Hyde Medical Center	
Nathan Littauer Hospital	Fulton
Little Falls Hospital	Herkimer
St. Mary's Healthcare	Montgomery
St. Mary's Hospital Memorial Campus	
Samaritan Hospital	Rensselaer
Saratoga Hospital	Saratoga
Bellevue Woman's Care Center of Ellis Hospital	Schenectady
Ellis Hospital	
Sunnyview Hospital	
Cobleskill Regional Hospital	Schoharie
HealthAlliance Mary's Avenue Campus	Ulster
Glens Falls Hospital	Warren

Western New York

Facilty Name	County
Cuba Memorial Hospital	Allegany
Jones Memorial Hospital	
Olean General Hospital	Cattaraugus
Brooks Memorial Hospital	Chautauqua
UPMC Chautauqua at WCA	
AHN Westfield Memorial Hospital	
Bertrand Chaffee Hospital	Erie
Encompass Health Rehabilitation Hospital of Erie	
Buffalo General Hospital	
Erie County Medical Center	
John R. Oishei Children's Hospital	
Kenmore Mercy Hospital	
Mercy Hospital of Buffalo	
Millard Fillmore Suburban Hospital	
Roswell Park Comprehensive Cancer Center	
Sisters of Charity Hospital	
Sisters of Charity Hospital — St. Joseph Campus	
United Memorial Medical Center	Genesee
Nicholas H. Noyes Memorial Hospital	Livingston
Bradford Regional Medical Center	McKean
Highland Hospital	Monroe
Rochester General Hospital	
Strong Memorial Hospital	
Unity Hospital of Rochester	
Unity Hospital of Rochester — Buffalo Road	
DeGraff Memorial Hospital	Niagara
Lockport Memorial Hospital	
Mount St. Mary's Hospital	
Niagara Falls Memorial Medical Center	
The Frederick Ferris Thompson Hospital	Ontario
Medina Memorial Hospital	Orleans
St. James Hospital	Steuben
UPMC Cole	Potter (PA)
UPMC Hamot Medical Center	Erie (PA)
Newark Wayne Community Hospital	Wayne
Wyoming County Community Hospital	Wyoming

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Vision and Dental

(Pennsylvania, West Virginia, Delaware, and New York)

For all products, at least one plan at each metal level (except Catastrophic) will have two versions: one plan with medical benefits only and another plan with identical medical benefits, plus adult dental and vision.

Benefits of vision coverage include:

- An annual eye exam.
- A $150 allowance for glasses or contacts.

Benefits of dental coverage include:

- The convenience of only having one bill to pay for comprehensive medical and dental coverage.
- Decreased waiting periods on certain services compared to Blue Edge Dental.
- Three free cleanings annually.

It pays to have dental coverage		
Service	**Average cost with dental coverage**	**Average cost without dental coverage (usual fee)**
Exams, Cleanings, and X-rays	$0 – 37	$288
Composite Filling	$71	$170
Simple Extraction	$33	$163
Root Canal	$400	$1,000

Vision network

Davis Vision Network

This network is custom and specific to Highmark.

Dental networks

United Concordia Advantage Provider Network

- PA: United Concordia Advantage Provider Network
- WV: United Concordia Advantage Plus Provider Network
- DE: United Concordia Advantage Plus 2.0 Provider Network
- NY: United Concordia WNY/NENY Elite Prime Provider Network

Blue Edge Dental

For members who would prefer a stand-alone dental plan, Highmark offers Blue Edge Dental plans. With Blue Edge Dental, members can choose from basic to comprehensive dental plans. Members have access to the United Concordia network of dentists.

Legal info

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Wholecare or Highmark Senior Health Company.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Wholecare, Highmark Choice Company or Highmark Senior Health Company.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. **Visit https://www.highmarkbcbswv.com/content/dam/highmark/en/highmarkbcbswv/member/redesign/pdfs/mhs/NetworkAccessPlan.pdf to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.**

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

BlueCard® is a registered mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

Healthmap Solutions (Healthmap) is a separate company that provides kidney population health management services for your health plan.

SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved. Tivity Health Inc. is a separate company that administers the SilverSneakers program.

Sword Health is an independent company that provides wellness services for your health plan. Sword Health Professionals provides its services through a group of independently owned professional practices consisting of Sword Health Care Providers, P.A., Sword Health Care Providers of NJ, P.C., and Sword Health Care Physical Therapy Providers of CA, P.C.

United Concordia provides the provider network for Blue Edge Dental and is a separate company that administers dental benefits. United Concordia is a separate company administering dental benefits.

Davis Vision, Inc. is a separate company that administers Highmark vision benefits.

Other Providers are available in our network.

Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Mental Well-Being is offered by your health plan and powered by Spring Health. Spring Health is an independent company that provides mental health care services through its agents. Spring Health is solely responsible for their mental health care services.

Well360 Virtual Health is offered by your health plan and powered by Amwell. Amwell is an independent company that provides telemedicine services and does not provide Blue Cross and/or Blue Shield products or services. Amwell is solely responsible for their telemedicine services.

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