

Dear Highmark Agent:

Welcome to Highmark Federal Markets — what we're calling our combined Medicare Advantage, Highmark Wholecare, and ACA Individual Market sales team. You're a valued member of this team, and the face of Highmark.

Change continues to be a constant in our industry, and not just in our streamlined approach behind the scenes. We are thrilled to expand our footprint into southeastern Pennsylvania. We are excited to continue excellent service in these communities.

As a Highmark field agent, you're often our first point of contact with consumers who are shopping for quality health coverage that is both accessible and affordable.

With this in mind, we've put together our Agent Field Guide to equip you with the tools and references you need to assist your clients more effectively.

This helpful resource puts a wealth of information at your fingertips — including details about our Medicare and ACA Individual Market products, important policies, and everything you need to know about doing business with Highmark. On the following pages, you'll also find guidance on using the Highmark producer web portal, information on the Medicare Star Ratings, and other insights to help ensure you're "Ready to Sell" Highmark products as the ideal solution to your customers' needs.

So please keep this guide handy. It can help you prepare to have more productive meetings with your clients as they search for a health plan offering both comprehensive coverage and real value.

Thank you for representing Highmark. And please know that we're always here to help you make your job easier and to help you remain successful.

Sincerely,

The Highmark Federal Markets Team

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SECTION I

Highmark Snapshot— Who Are We?

Welcome to Highmark Health, a health and wellness organization with more than 35,000 employees.

A national blended health organization, Highmark Health and our leading businesses support millions of customers with products, services, and solutions closely aligned to our mission of creating remarkable health experiences, freeing people to be their best.

Headquartered in Pittsburgh, we're regionally focused in Pennsylvania, Delaware, West Virginia, and New York, with customers in 50 states and the District of Columbia.

We passionately serve individual consumers and fellow businesses alike. And our companies cover a diversified spectrum of essential health-related needs including health insurance, health care delivery, population health management, dental solutions, reinsurance solutions, and innovative technology solutions.

Highmark Health's portfolio of leading health care companies





Highmark Inc. | Pittsburgh, PA

Highmark Inc. and its collective health insurance subsidiaries and affiliates are one of America's largest health insurance organizations.

Highmark Inc. and its affiliates operate health insurance plans in Pennsylvania, Delaware, West Virginia, and New York that serve more than 6 million members and hundreds of thousands of additional individuals through the BlueCard® program.

Together with its Blue-branded affiliates, Highmark Inc. is the fourth-largest overall Blue Cross and Blue Shield affiliated organization in the country based on capital.

Highmark Inc. is an independent licensee of the Blue Cross Blue Shield Association.





Highmark Wholecare is a leading Medicaid and Medicare insurer. They coordinate health care that goes beyond doctors and medicine, driving a new kind of health care in collaboration with a robust provider network of 30,000 doctors and specialists across Pennsylvania. Highmark Wholecare is committed to supporting the "total health" of its members.

United Concordia® Dental

United Concordia Dental is a leading national dental solutions company focused on delivering better, overall health. The company has nearly 8.5 million members, one of the nation's largest dentist networks, an AM Best A- (Excellent) rating, and is licensed in all 50 states, District of Columbia, and Puerto Rico.



HM Insurance Group works to protect businesses from the potential financial risk associated with catastrophic health care costs. Through its insurance companies, HM Insurance Group holds insurance licenses in 50 states and the District of Columbia and maintains sales offices across the country.



enGen's dynamic ecosystem of smart automation, and technology supports and streamlines complex operations for health plans and their provider partners. Founded in 2014 as HM Health Solutions (HMHS), enGen is a wholly owned subsidiary of Highmark Health. enGen has more than 3,500 employees and works with health care plans serving more than 10 million members nationwide.



Allegheny Health Network provides health care delivery, research, medical education, and wellness services through a leading integrated delivery network of 13 hospitals, more than 2,500 staff physicians, and key clinical and research partnerships.



Helion is a health care technology and services firm that helps payers cultivate high-performing networks while empowering providers to operate at their best — and in doing so, helps patients heal better. The firm's end goal is health and healing in the home, but their solutions create value along a broader part of the health care continuum.

SECTION II

Doing Business with Highmark Federal Markets

The Producer Portal

Highmark offers plenty of helpful resources to make your job easier — including our Producer Portal. This user-friendly website has everything you need to understand our plans and communicate effectively with clients.

Producer Portal is only for Medicare and ACA lines of business, not D-SNP.

With the Producer Portal, you can:

- Enroll clients online.
- Check the status of applications.
- Order customized enrollment kits.
- Request CMS-approved marketing materials.
- View and download important documents.
- Access the most recent version of this Field Guide.



Enroll your clients in just a few steps

Our online enrollment tool allows you to enroll your clients quickly and easily. It also provides instant confirmation that an application has been received by Highmark.

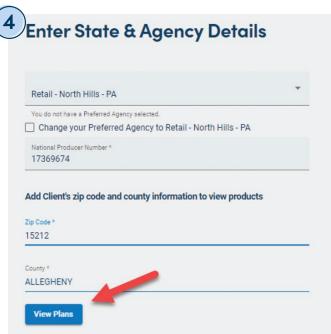
To use the online enrollment tool:

- 1. Log in to the **Producer Portal**.
- Select your Line of Business. (Note: to access the Medicare Producer Portal directly, you can use this address — medicare.highmark.com/producer/ login.) If you're logging into ACA Individual Market, you then select On Exchange Plans or Off Exchange Plans. Individuals can only enroll online for off-exchange plans during the Open Enrollment Period.
- 3. Select the **Start Enroll** button from your Dashboard, or under **Quick Links**.
- 4. Enter the ZIP code and select the county the beneficiary lives in. Then, choose **View Plans** to make a selection.
- 5. Next you will come to the **Review** screen. At this screen, you can print out a summary of the application.
- 6. After you submit the application, you will be directed to a confirmation screen. Here you can email yourself a confirmation for your records.









Checking the status of an application

Once you submit an application to Highmark via online enrollment, you can check its status through the Producer Portal.

Here's how:

- 1. Log in to the **Producer Portal**.
- 2. Applications will be listed at the bottom of your Dashboard screen.

Alternatively:

- 1. Click on the Reports link under Quick Links.
- Review Recent Activity including Pending Applications from this secondary Dashboard.

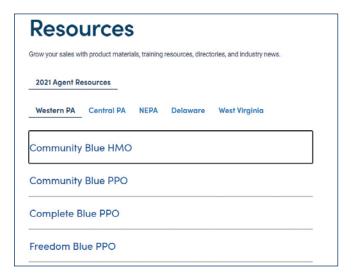
Viewing and downloading documents

The Producer Portal has important documents that producers can use to market and sell Highmark Medicare and ACA Individual Market Products.

To access these documents, click on the **Resources** link under **Quick Links** on your Dashboard. All documentation available to producers will be listed by product and region, including additional resources like the **Scope of Appointment** document.







Sharing PURLs from the Producer Portal

Sharing PURLs applies to Medicare Advantage only.

Your PURLs (Personalized URLs that lead to specific web landing pages) are an easy way to send enrollment kits and roadmaps with your details attached, so that you get credit for resulting enrollments. Sending PURLs from the Portal allows you to track what members or prospects do with them.

When you log in to the Portal, you'll notice two new Quick Links in your Dashboard: **Send Referrals** and **PURL Activity**.

From **Send Referrals**, your details are prepopulated and you can enter your prospect's ZIP code, county, and email address, then select the type of referral you're sending (referral email, enrollment kit, or roadmap kit).

Click **Send Email**, and the referral is sent. **We strongly urge you to send PURLs directly from the Producer Portal in this way.** This ensures the activity is tracked in your PURL Status Tracker dashboard.

Clicking **PURL Activity** sends you to the **PURL Status Tracker**. This page displays the actions your prospects have taken with your Portal-sent PURLs (email sent, link clicked, app saved, app submitted) in both a bar graph overview and a more detailed list.

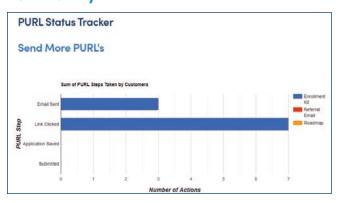
For a more detailed overview and walkthrough of these new features, go to the Send Referral link and click on the PURL Reference Guide.

Send Referrals



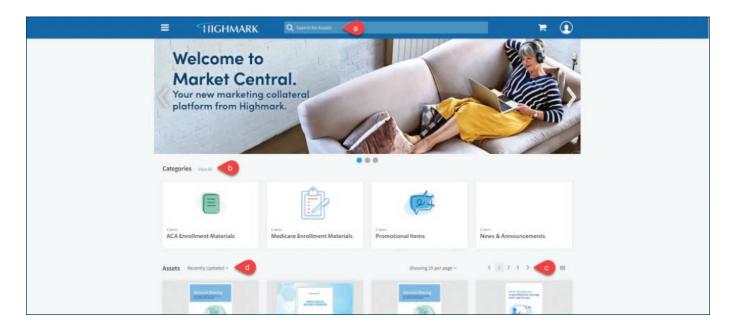


PURL Activity



Using Marcom — our online source for enrollment kits and support materials

Highmark agents have one website for all of their marketing materials and enrollment kits. To get started, log in to **Highmark Producer Portal** at **producer.highmark.com**. From the **Medicare Advantage** dashboard, you can access Marcom by selecting the **Order Supplies-Over 65** link under **Quick Links**.

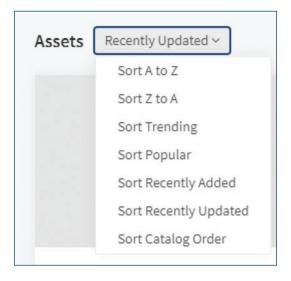


How to navigate

You can search the portal a few ways:

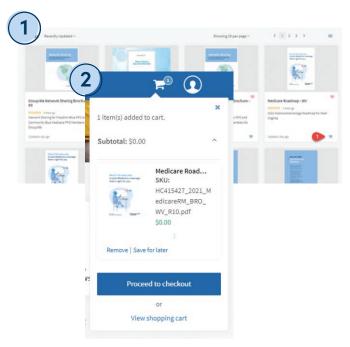
- 1. Typing in the Search Bar.
- 2. Scrolling through the pages.
- Home Page view/toggling between the different view options.

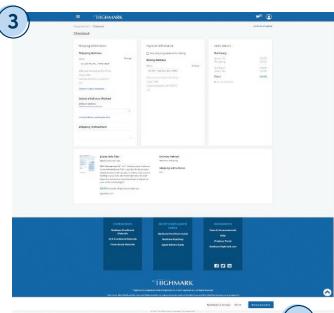




How to check out

- Select the product you would like to order and click on the **Cart icon** to add it to your cart. If the piece requires customization, you must complete that first and then select **Add to Cart** after generating a proof.
- 2. Once you add to the cart, a preview will show in the top right of the page.





- Click the View Shopping Cart or the Proceed to Checkout button to begin the checkout process. You'll be asked to fill out your Shipping and Billing Information. Once you've completed that, hit Refresh order details at the bottom to apply your changes to the order.
- 4. Click the **Review and Confirm** button.
- 5. Review your order details and click **Complete Order**.
- 6. Your order is placed, and you will receive your order number.

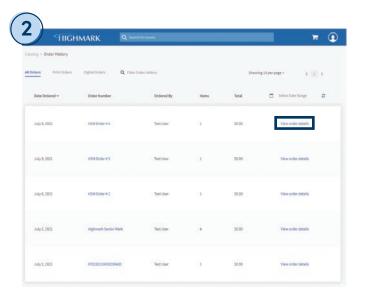


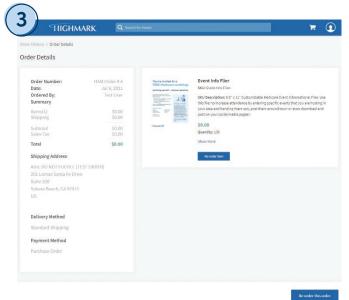


How to check order history

- 1. To check on past orders, navigate to the menu icon in the top left corner and select **Order History**.
- 2. You'll see all orders listed by date. You can also search by order number, date range, and more.
- 3. You can select the **View order details** link to see which items were included in each order. You will also be provided a link to reorder if you'd like.







How to talk to your clients about eBill

The easiest way to pay

Coverage starts once a member reaches their coverage effective date and make their first payment. The simplest way to do that is by registering for an eBill account. After that, they can set up automatic payments to make paying on time even easier. Here's how to get started:

- Create an account by visiting our secure member website and selecting the Register link.
 They'll need their Highmark member ID.
- 2. Receive and pay the first invoice.
- 3. Set up automatic payments, so they never miss one. Missing a payment can lead to loss of coverage.

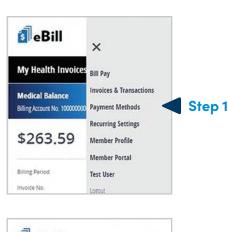
Making payments

Step 1:

Members can log into their account and click the **Pay Premium** tab. This will take them to the eBill landing page.
If they're using a mobile device, they can click the three lines in the upper right-hand corner to access the menu.

Step 2:

Under **My Health Invoices**, they can find their invoice and tap **Pay Now** in the blue bar.





Step 3:

Next, they'll need to add a payment method.

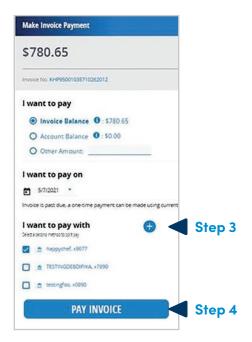
 They can tap the blue plus symbol to the right of I want to pay with. From there, they can enter the details of their preferred payment method, then tap Add Payment.

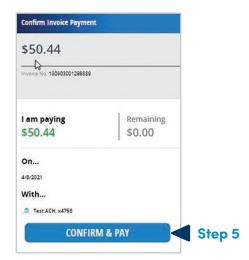
Step 4:

Once their preferred payment method is added, they should tap **Pay Invoice**.

Step 5:

On the **Confirm Invoice Payment** page, they can make sure all the information is correct and then tap **Confirm and Pay**.





Signing up for automatic payments

Step 1:

Members can go to **Recurring Settings** on the main menu and tap **Add Recurring Payment**.

Step 2:

Select the **Coverage Type** from the drop-down menu.

Step 3:

Select the number of days before the due date to pay the bill from the drop-down menu (0-10), then select a starting date for the recurring payment.

 If the box below the starting date is unchecked, a second box will appear for the ending date. Make payments until coverage ends is the default.

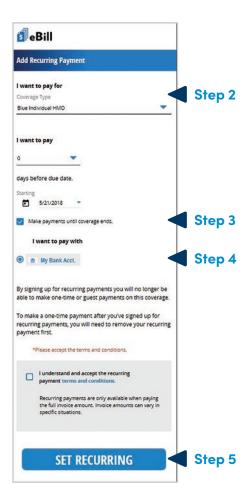
Step 4:

The member's preferred payment method will automatically be selected. If they want to use multiple payment methods, they can uncheck the preferred payment method and choose another.

Step 5:

Tap the checkbox to accept the terms and conditions, then click **Set Recurring**.





Ethics and Integrity

Highmark Health and its Blue-branded health plans are committed to complying with all applicable federal and state regulatory requirements.

Highmark Health and is affiliates/subsidiaries policies and procedures deal with direct black and white types of situations. But more often than not, life happens in gray areas. This is where the Code of Business Conduct comes in.

The Code outlines Highmark Health's ethical standards and behavioral expectations. You are required to read, understand, and agree to abide by the Highmark Health Third Party Code of Business Conduct.

As an appointed agent, you have the responsibility to comply with our Third Party Code of Business Conduct.¹ You are required to conduct business activities and interactions ethically and with integrity. You must adhere to the following standards:

- Seek to truthfully, carefully, and accurately present a true picture of covered benefits by learning about and keeping abreast of all relevant products, benefit plans, and applicable legislation and regulation, to the best of your ability.
- Make a conscientious effort to ascertain and understand all relevant circumstances pertaining to the client in order to recommend appropriate benefit plans.
- Inventory current benefit plans with the client to avoid selling duplicative insurance benefits.
- Honestly assess the likelihood that a client will meet underwriting and financial requirements and discover any adverse factor(s) to reduce false expectations of acceptance and adequacy of benefit plan.

- Possess a comprehensive understanding of products in order to honestly, openly, and effectively portray benefit plans and determine a client understanding of key benefits and limitations.
- Clarify and verify the client's grasp of information and review pertinent issues.
- Protect proprietary and competitive information.
- Protect protected health information, confidential and financial information in compliance with existing state and federal laws and regulations.
- Obey all laws, including antitrust, governing business, and professional activities and represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics, or concealment of pertinent facts.
- At all times, fully disclose commission and compensation arrangements to the client.
- Ensure appropriate relationships by not offering or accepting any inducements that might compromise a reasonable business decision. Avoid any conflict of interest or the appearance of any conflicts of interest.
- Use only authorized promotional materials unless prior written approval has been obtained, and fairly focus your presentation on positive benefit comparisons, rather than disparaging remarks about the competition.
- Treat a client or a potential client with courtesy, respect, and priority, in accordance with thoughtful, ethical, and legal business practices.

A copy of Highmark Health's Third Party Code of Business Conduct may be found at highmarkhealth.org/hmk/pdf/highmarkHealthThirdPartyCodeBusinessConduct.pdf

You are obligated to report any questionable behavior by employees of Highmark Health and/ or its subsidiaries/affiliates, a third party, and/or its employees and agents or potential noncompliance situation, or if you suspect potential or actual fraud, waste, or abuse ("FWA"), you should contact the Highmark Health Integrity and Compliance Department. In addition to being a resource for Highmark Health employees, the Integrity and Compliance Department is available for questions by Highmark Health business agents like you. When a report is made to the Integrity and Compliance Department, appropriate action is taken to review and/or investigate the report to reduce the potential for recurrence and ensure ongoing compliance. Third Parties are expected to cooperate with the investigation of a suspected violation of this Third Party Code or violation of any governmental law or regulation. In addition, as required and/or appropriate, the Integrity and Compliance Department may disclose investigation matters to applicable law enforcement or regulatory entities. Failure to promptly report a known violation may result in action up to and including termination of the business relationship and is the sole discretion of Highmark Health.

There are various methods for reporting concerns:

- 24/7 Helpline: 800-985-1056
- U.S. Post Office Box: Highmark Health Integrity and Compliance Department, P. O. Box 22492, Pittsburgh, PA 15222
- Fax: 412-544-2475
- Email: integrity@highmark.com

All inquiries to the Integrity and Compliance Department are confidential, subject to limitations imposed by law. When using the Integrity Helpline, you may remain anonymous. If you choose to make an anonymous report, you should provide enough information about the situation to allow the Integrity and Compliance Department to properly perform an investigation. If you do not provide enough details, the ability to pursue the matter will be limited. Highmark Health maintains a reprisal-free environment and has a policy of non-retaliation and non-intimidation to encourage employees, Third Parties, and their employees to raise ethical or legal concerns in good faith. Third Parties who raise questions or report concerns regarding potential or actual FWA matters in connection with any of Highmark Health's government programs are protected from retaliation and retribution for False Claims Act complaints, as well as any other applicable anti-retaliation protections. All inquiries are confidential, subject to limitations imposed by law. The Third Party Code sets forth general principles with which Third Parties must comply. More restrictive requirements may be set forth in the contracts between Third Parties and Highmark Health.

Commissions, Compliance, and Agent Oversight*

Compensation

Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fees.

Compensation **DOES NOT** include:

- The payment of fees to comply with state appointment laws.
- Training.
- · Certification.
- Testing costs.
- Reimbursement for mileage to, and from, appointments with beneficiaries.
- Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

Commissions

We pay a commission to agents for each person they enroll in a Highmark product in accordance with the CMS requirements, agent eligibility, and our commission schedules. The compensation year is Jan. 1 – Dec. 31, regardless of beneficiary enrollee date.

To qualify for commissions, agents must:

- Not be on Office of the Inspector General (OIG) and/or the General Services Administration–System for Award Management (SAM). We check them initially and every month thereafter.
- Complete the contract, state licensing, appointment, and certification process prior to the sale of the policy. (You will not receive commissions for applications submitted before all contracting and certification requirements are met.)
- Complete the annual certification process, including market-specific product training(s) to receive renewal commission for policies active in the current year, and meet other requirements set forth in your contract.
- Be in good standing with their plan. Disciplinary action may result in the disqualification of commission.
- Please refer to your appointment documents and/or the General Producer Agreement for more information about eligibility for commissions.

In addition, to receive renewal commission in January for business sold in prior years, you must complete the annual certification process by Dec. 31.

Note: The annual certification process must be completed by Dec. 31 to receive renewal commissions in January. If you choose to recertify after Dec. 31, prorated renewal commission payments to you will resume the first month after certification is complete. You will not be eligible for any missed commission payments during your lapse period.

^{*} Per CMS guidelines, some information may only pertain to Medicare.

Compliance

Highmark is committed to full compliance with federal and state regulatory requirements applicable to its Federal Markets plan business.

Highmark, its employees, and contractors are expected to meet the contractual obligations set forth in the company's contracts with the Centers for Medicare and Medicaid Services (CMS).

In order to achieve these objectives, Highmark conducts its business in compliance with — and does not tolerate any violation of — applicable federal and state health care regulations.

Potential consequences of engaging in inappropriate or prohibited marketing activities include disciplinary actions, termination, and forfeiture of compensation. Agents for Highmark's covered programs are required to comply with the new ACA Section 1557 regulations as of July 18, 2016. Any agent that engages in prohibited discrimination in connection with the marketing of a Highmark covered program will be subject to disciplinary action including the termination with cause of their Producer Agreement.

At the time of contract, the following will be verified:

- Active License (with Accident and Health Line of Authority)
- Annual Certification (including the Annual FWA and Compliance training and Integrity training)
- Appointments to the appropriate Highmark companies

In addition, ongoing communication will occur through email blasts, webinars, group meetings, and one-on-one consultations. Training will reinforce the need for strict compliance and will advise producers that any failure to comply will be documented and may result in disciplinary action up to and including possible termination.



Agent Oversight

Highmark employs several monitoring procedures to ensure that certified agents are complying with all CMS sales and marketing guidelines and Highmark Federal Markets Sales policies. If any compliance deficiencies are identified through these monitoring procedures, the agent is subject to the disciplinary action process outlined later in this section. Violations could result in agent's receiving education, non-commissionable sales, or even termination.

These procedures include:

Secret Shop Evaluations

- Highmark utilizes a vendor to conduct periodic secret shopper evaluations of producers selling Highmark Medicare products.
- Highmark Federal Markets Sales reviews the evaluations reported to verify that the producer is complying with all applicable CMS sales and marketing guidelines.

Telephonic Phone Surveys

 Highmark calls a random sample of members enrolled through producers as part of the New Member Welcome Call process and requests that the member complete a survey addressing the producer sales process.

Complaint Allegation Tracking

 Highmark investigates, monitors, and tracks any and all complaints that are received against producers.

Untimely Application Tracking

 Highmark investigates, monitors, and tracks any and all applications received after 48 hours.

Scope of Appointment Audits

- Highmark expects that all agents maintain complete and separate records of all transactions and documents pertaining to applications submitted to and accepted by Highmark for a period of at least 10 years after the contract year.
- To ensure that all producers are complying with the CMS guidelines that require records to be kept for 10 years, a random sample of agent-submitted agreements will be selected and the agent will be required to provide the Scope of Appointment.

Rapid Disenrollment and Cancellation Tracking

- Highmark's Producer Agreement stipulates that:
 - The total Initial or Renewal commission will be charged back if the enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment).
 - An "unreasonably short time frame" is defined as less than three months after enrollment.
 - Upon receipt of a notice of disenrollment that occurs three months or more after enrollment, Highmark will withhold or withdraw ("chargeback") commission payments on a pro rata monthly basis to the effective date of the disenrollment.
 - Highmark will also assess chargeback for rapid disenrollments in accordance with CMS guidelines.

Sales and Marketing Events

During marketing/sales events, plan representatives may discuss plan-specific information (i.e., premiums, cost sharing, and benefits), distribute health plan brochures and enrollment materials, and accept and perform enrollments.

There are two types of sales and marketing events

(Both follow the same CMS marketing guidelines.)

- Formal: Typically in an audience/presenter format with an agent, broker, or producer formally providing specific plan or product information via a presentation.
- Informal: Conducted with a less structured presentation or in a less formal environment.
 Typically utilizes a table, a kiosk, or a recreational vehicle (RV) staffed by a plan representative who can discuss the merits of the plan's products.
 Beneficiaries must approach you first.

Key Requirements and Important Notes

- Use only our CMS-approved sales scripts, presentations, and sales presentations notes/talking points during all Highmark marketing/sales events.
- Formal and informal marketing/sales events do not require documentation of beneficiary agreement on a Scope of Appointment form. Do not request or obtain one. CMS views this as pressuring for personal contact information.
- A beneficiary may complete a Scope of Appointment at a marketing/sales event for a future appointment.
- Upon arrival to an informal or formal event, check in with the venue so they know you are on site, and have the verification form signed at that time.

- Do not market non-health care related products such as annuities and life insurance (cross-selling) to prospective enrollees during MA/MAPD or PDP marketing/sales events.
- All marketing/sales events must meet event requirements. Exception: If only one beneficiary attends a formal event, you can discuss the MA/ MAPD and/or PDP products on an individual basis (must go with attendee's preference — full presentation or informal discussion). A Scope of Appointment is not required under this exception.
- You will not receive commission for any sale that results from an unreported marketing/sales event.
 Failure to report events can result in termination of your Highmark contract.
- New agents received marketing/sales event reporting information during their certification training. This information is also located in agent annual training/testing material, CMS Medicare Marketing Guidelines, this Highmark Medicare Producer Guide, and on the Highmark Producer Portal.
- All documentation must be saved for at least 10 years and available upon request by Highmark or CMS.

Prohibited Activities

- Conducting health screening, genetic testing, or other like activities that give the impression of "cherry picking."
- Requiring beneficiaries to provide any contact information as a prerequisite for attending an event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through the mail.
- Using personal contact information for any other purpose other than to notify individuals of a raffle or drawing winning.
- Comparing Highmark to another organization or plan by name unless you obtain written consent from all organizations or plans being compared. You must provide this written consent to us for submission to CMS.

- Providing meals to attendees. However, light snacks and refreshments are permitted.
- · Asking a beneficiary for a referral.
- Soliciting or accepting an enrollment application for a Jan. 1 effective date prior to the start of the Annual Enrollment Period (Oct. 15 – Dec. 7) unless the beneficiary is entitled to another enrollment period.
- Marketing or advertising Medicare plans or events for the upcoming plan year prior to Oct. 1.
- Using absolute superlatives like "the best,"
 "highest ranked," or "rated number 1," or qualified
 superlatives like "one of the best," or "among the
 highest ranked," unless they are substantiated with
 supporting data provided to CMS as a part of the
 marketing review process.
- Claiming you or Highmark are recommended or endorsed by CMS, Medicare, or the Department of Health and Human Services.
- Offering nominal gifts in the form of cash or other monetary rebates, even if their worth is \$15 or less.
 Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash.

Scope of Appointment Form

The Centers for Medicare and Medicaid Services require agents to document the scope of a marketing appointment prior to any face-to-face or telephonic sales meeting to ensure understanding of what will be discussed between the agent and the beneficiary.

If the agent would like to discuss additional products during the appointment, the agent must document a second Scope of Appointment (SOA) for the additional product type.

- It is the responsibility of the agent to secure an SOA for every sales appointment.
- The agent must retain a copy of the SOA for 10 years after the contract year per CMS regulations whether an enrollment is received or not.
- All information provided on the form is confidential and should be completed by each person with Medicare.
- When conducting a sales meeting, the agent may not market any health care-related product beyond what was agreed upon on the SOA form.

Note: A copy of the Highmark Scope of Appointment (SOA) can be found in the Appendix at the end of this guide.

The following five activities are mandatory.

You must:

- 1. Report all marketing/sales events prior to advertising the event or 21 days prior to the event's scheduled date, whichever is earlier.
- 2. Use one of our CMS-approved sales presentations from beginning to end every time you meet with a beneficiary to discuss our products and read the sales presentation notes/talking points as part of the script. The sales presentation video must use in conjunction with the CMS-approved sales presentation.
- 3. Announce all products or plan types to be covered during the presentation at the beginning of the presentation (i.e., HMO, PPO, PDP, etc.).
- 4. When providing an enrollment form, you must also provide the following materials: 1) Star Ratings information, 2) Summary of Benefits, and 3) Multi-Language Insert.
- 5. If using non-Highmark sign-in sheets, clearly write in large letters across the top: "Completion of any contact information is optional."

Agent Disciplinary Policy for Minor and Severe Violations

Minor Violations

Minor violations are taken seriously and may require immediate disciplinary action. Disciplinary action may include, but is not limited to, withholding commissions and/or the retraction of commissions. The results of each investigation will be reviewed by the Federal Markets Sales Department to determine the appropriate disciplinary action. Minor violations are tracked over a rolling two-year period.

Violations in this category include, but are not limited to:

- Untimely broker application submissions
 - Highmark requires applications to be submitted within 48 hours of signature from the customer.
 This pertains to both online enrollments and paper applications.

Rapid disenrollments

- Rapid disenrollments will be reviewed for any trends or patterns amongst individual agents.
- Highmark's Producer Agreement (Schedule C, Section B, Subparts 5 and 6) stipulates that:
 - » The total Initial or Renewal commission will be charged back (as set forth below) if an enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment). An "unreasonably short time frame" is defined as less than 90 days after enrollment.
 - » Upon receipt of a notice of disenrollment that occurs 90 days or more after enrollment, Highmark will withhold or withdraw ("chargeback") commission payments on a pro rata monthly basis to the effective date of the disenrollment. Highmark will also assess chargebacks for rapid disenrollments in accordance with CMS guidelines.

Minor Violation Disciplinary Procedures

- First Offense: A first violation committed by the agent will result in an official warning to the agent and/or their general agency or FMO, as applicable, alerting them of the infraction.
- Second Offense: A second violation committed by the agent will result in a secondary warning and education on Highmark's policies and procedures.
- Third Offense: A third violation will result in withholding or retraction of commissions on any sale or application(s) relating to the violation. Depending on the nature of the third offense, the commission retraction could be one or multiple applications relating to the offense. This is at the sole discretion of the Federal Markets Sales Department.
- Persistent Minor Violations: Persistent violations disciplinary action may include, but is not limited to, suspension and/or termination of contract.

Any agent found to have committed a minor violation may be educated by the appropriate member of the Federal Markets Sales Department. The agent may be required to repeat the company's sales training program before being permitted to resume selling Highmark Federal Markets products.

Committing a minor violation may be considered grounds for further action to be taken including, but is not limited to, suspension, termination, and/or retraction of commissions.

- Founded Complaints Tracking Module (CTM) or Member Service complaint
 - Each complaint is independently investigated by a Highmark compliance individual.
- CMS compliance violation during sales interaction
- Presenting competitor information during Highmark event or Highmark scheduled appointment

Severe Violations

Severe violations are non-compliant activities deemed egregious in nature, which may result in immediate contract suspension, termination, and/or retraction of commissions.

All allegations of severe violations are investigated by the Federal Markets Sales Department with support from the Compliance Department.

Violations in this category include, but are not limited to:

- Dishonesty or theft.
- Threatening, coercing, intimidating, or deceiving a member or prospective member, or the use of any other unethical sales tactics.
- Door-to-door solicitation.
- Misrepresentation of the product, the purpose of the producer's visit, or an implication that the visit is in any way connected with the government.
- Forging or knowingly accepting a forged signature on an enrollment form.
- Mistreatment of Highmark employees and/or contractors.
- Deliberate or negligent omission or falsification of significant information on any company form.
- Sales of a product by any individual other than the licensed producer who presented the product and signed the enrollment form.
- Accepting any monetary or other rewards including, but not limited to, rewards for influencing the enrollee's choice of physician, medical center, or pharmacy.
- Willful use (with intent to misrepresent) of marketing material(s) not provided by the company, and therefore not filed with and approved by CMS for use.
- Rebating or splitting commissions with another person who is not a licensed and contracted producer (i.e., payment of any kind or amount to a member or non-member as reimbursement for

Severe Violation Disciplinary Procedures

- A severe violation committed by the agent will result in a notification to the agent and/or their general agency, as applicable, alerting them of the infraction. This notification will alert the agent and/or their general agency, as applicable, that they have been accused of a severe violation and that an investigation will be conducted.
- After the investigation is completed, if it is confirmed that the agent committed the infraction, immediate contract suspension, termination, and/or retraction of commissions may result.
- The results of each investigation will be reviewed by the Federal Markets Sales Department to determine the appropriate disciplinary action, at which point the agent will be notified of their contract status with Highmark.

Highmark will report any disciplinary action that results from an investigation of a complaint to CMS in accordance with the CMS Reporting Requirements. Disciplinary action taken could fall within a broad continuum, from manager-coaching, documented verbal warning, retraining, a documented corrective action plan, suspension, commission retraction, or termination of employment or contract.

Highmark will report the termination of any agents and the reasons for the termination to the state in which the agent has been appointed in accordance with the state appointment law. Highmark will make the report available upon CMS' request until further guidance has been issued regarding designated reporting dates to CMS.

In addition, Highmark will report incidences of submission of applications by unlicensed agents to the authority in the state where the application was submitted.

a referral name on the condition that the referred person purchases one of our products).

- Any marketing activity that is a violation of Highmark's, CMS, or DOI regulations.
- Marketing or selling products for the following year prior to the CMS determined Annual Enrollment Period (AEP) or Open Enrollment Period (OEP) marketing date.
- Marketing or selling products for a contract year prior to taking the annual Highmark-specific training on rules and regulations and passing the test with a score of at least 85%.

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.

SECTION III

Medicare Advantage

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Highmark's Medicare Advantage Star Ratings

The Centers for Medicare and Medicaid Services (CMS) created the Part C and D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health plan.

What do the Medicare Advantage Star Ratings really mean?

Each Medicare Advantage contract receives a single Star Rating from CMS annually. A contract is made up of one or more Product Benefit Plans (PBPs) or simply "plans." Performance data for members enrolled in those plans are collectively used to calculate the contract's overall Star Rating. The Star Rating associated with each plan represents the overall contract's Star Rating.

Plans offering access to health services are scored on the quality of many different measures that fall into five categories:

1. Staying healthy: screenings, tests, and vaccines

 Includes whether members got various screening tests, vaccines, and other checkups that help them stay healthy.

2. Managing chronic (long-term) conditions

 Includes how often members with different conditions got certain tests and treatments that help them manage their condition.

3. Member experience with the health plan

- Includes ratings of member satisfaction with the plan.

Member complaints and changes in the health plan's performance

- Includes how often Medicare found problems with the plan and how often members had problems with the plan.
- Also includes how much the plan's performance has improved (if at all) over time.

5. Health plan customer service

 Includes how well the plan handles member appeals. Plans offering prescription drug coverage are scored on the quality of many different measures that fall into three categories:

Member complaints and changes in the drug plan's performance

- Includes how often Medicare found problems with the plan and how often members had problems with the plan.
- Also includes how much the plan's performance has improved (if at all) over time.

2. Member experience with the drug plan

- Includes ratings of member satisfaction with the plan.

3. Drug safety and accuracy of drug pricing

 Includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Why do Star Ratings matter?

- Achieving strong Star Ratings helps Highmark sustain choice and affordability for Medicareeligible customers in our service area.
- Our Star Ratings performance reflects our commitment and ongoing investment in improving the health care experience for our members.
- The financial benefit of favorable Star Ratings will also help us keep a strong and consistent option for Medicare Advantage customers.
- Plans that achieve a rating of five stars are considered to be the top quality performers in serving Medicare beneficiaries. Beneficiaries are able to switch into a five-star plan at any time throughout the year, once per calendar year.
- Low-performing plans (below three stars) are at risk of having enrollment blocked by the federal government or being removed entirely from the Medicare program.

Lagging timeline

Star Ratings are not on the typical one-year planning cycle, where what we do this year impacts next year. Instead, the annual Star Ratings reflect performance from two years prior. For example, how we performed in calendar year 2021 was used by CMS for our 2023 star ratings.

How can you positively impact Star Ratings?

You are the face of our plan and how you portray our plans and interact with your clients can positively affect our Star Ratings. Your professionalism and accuracy are very important to some of the performance categories measured by CMS, especially for the member satisfaction category. You can positively impact Star Ratings by being accurate when you present a plan and by encouraging members to use their benefits, complete an annual wellness visit, seek appropriate care, complete preventive screening and tests, and adhere to their medications. You must be able to:

- Know the benefits you are selling, accurately explain the plan, and determine the best fit for the consumer. This supports the consumer with their plan selection, strengthens your relationship, and may also help avoid complaints.
- Encourage consumers and members to use their benefits because Star Ratings are influenced by whether or not our members obtain specific services, such as: receiving annual screenings and preventive care, visiting their primary care physician (PCP), and properly using their medications (referred to as "medication adherence").
- Reduce the chance that any type of complaint would be filed by doing what is required in all sales presentations and appointments and lending proper support to your consumers.
- Earn high scores on your sales events if you are secret-shopped by mentioning all required statements and showing consumers all required materials. One of the things you are required to cover is information on Star Ratings.

Highmark 2023 Star Ratings¹

Highmark has the largest 5-star PPO plan in Pennsylvania.

Highmark Senior Health Company (Freedom Blue PPO, Community Blue Medicare PPO, and Complete Blue PPO)



Highmark Choice Company (Security Blue HMO-POS and Community Blue Medicare HMO)



HM Health Insurance Company (Blue Rx PDP)



Highmark Senior Solutions Company (Freedom Blue PPO — West Virginia)



Highmark Blue Cross Blue Shield of Western New York (PPO)



Highmark Blue Cross Blue Shield of Western New York (HMO)



Highmark Blue Shield of Northeastern New York (PPO)



Highmark Blue Shield of Northeastern New York (HMO)



 $^{1.} Reference\ medicare.gov\ or\ cms.gov/Medicare/Prescription-Drug\ Coverage/PrescriptionDrug\ CovGenIn/PerformanceData.html.$

Enrollment Processes

Before completing an enrollment application with a beneficiary, you must confirm that the prospect is eligible, i.e., entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan.

Examples of acceptable proof of eligibility include:

- A copy of a Medicare card.
- A copy of a Medicaid award letter for dual-eligible Special Needs Plans.
- A Social Security Administration award notice.
- A Railroad Retirement Board letter of verification.
- A statement from the Social Security Administration or Railroad Retirement Board verifying the consumer's Medicare eligibility.

When you make a presentation to any prospect, be sure to use only a current Highmark CMS-approved sales presentation to ensure you've covered all required information. Once you have completed the application, you may submit it to Highmark via any of the methods below:

- 1. Secure Fax: 888-663-0258
 - Applications will not be accepted via any other fax number.
 - Applications must be faxed within 48 hours of receipt.
- 2. Online through the Highmark Producer Portal medicare.highmark.com/producer/login
- 3. Phone Number: 866-673-9112
 Once you have completed a phone consultation with the prospect and the prospect is ready to complete the enrollment, you may conference call our dedicated enrollment line for the beneficiary to complete the enrollment telephonically. (The personnel staffing the enrollment line are unlicensed agents and will not be able to provide consultative assistance to you or the beneficiary. If the beneficiary has any plan-specific questions, they will be directed to call their agent back to assist before completing the enrollment.)

Required information: Please provide the agent with your name and NPN, the beneficiary's name, and the plan they wish to enroll in. The agent staffing the line will then process the enrollment telephonically. To ensure all applications are properly processed, you must send the beneficiary's name, DOB, and the selected plan to highmarkseniormarkets@highmark.com.

What happens next?

If the enrollment application is complete,

Highmark will submit the completed enrollment application to the Centers for Medicare and Medicaid Services (CMS). CMS will determine approval for requested coverage.

Once the enrollment application is approved by CMS, the member will receive:

- An enrollment verification letter.
- A welcome kit (mailed within seven days of CMS acceptance).
- An ID card (mailed within 10 days of CMS acceptance).

If the enrollment application is denied, the member will receive a denial letter with the reason for denial. This is mailed within 10 days of the application denial.

If the enrollment application is incomplete,

Highmark will reach out to the member and/or agent by phone and/or written communication to obtain the missing information. If the missing information is received within 21 days, or the end of the current month (whichever is later), the enrollment application will be submitted to CMS. CMS will determine approval for the requested coverage. If the missing information is not received in time, the application will be denied.

Products Overview

Who is eligible for it, and how does it work?

Medicare is health insurance that the U.S. government provides for people over 65, or for some disabled persons. Medicare is made up of four parts – Part A, Part B, Part C, and Part D. Parts A and B comprise what is known as Original Medicare, for which most people are eligible when they turn 65. Part A is automatic. Parts B, C, and D are optional.

Part A

Part A is hospital insurance that helps pay for things like inpatient hospital stays, skilled nursing care, hospice, and limited home health care. If your prospective client or their spouse has worked a minimum of 10 years and paid in at least 40 quarters of Medicare taxes, they are automatically enrolled in Part A with no monthly premium.

Part B

Part B is medical insurance that helps pay for doctor visits, outpatient procedures, diagnostic tests, medical supplies, and vaccines. Preventive benefits, like certain screenings such as mammograms, diabetes, and prostate screenings, are also included. Most people have to sign up for Part B, and it typically comes with a standard monthly premium that is determined by income.

Part C

Private insurance companies like Highmark offer Part C plans, which are called Medicare Advantage. These plans act as primary insurance instead of Original Medicare. These plans help with the hospital costs, doctor visits, and other medical services that are covered by Original Medicare. Plus, these plans offer worldwide emergency and urgent care, and many include coverage for prescription drugs, routine vision, hearing, dental, and even gym memberships.

Medicare Part D

Insurance companies like Highmark also offer Medicare Part D, and it helps pay for prescription drugs.

Each prescription drug plan has a list of generic and brand-name drugs that are covered by that plan, and that list is called a formulary. Each drug is assigned to a tier, which determines how much your client will pay for that drug. Highmark has a transition process to accommodate the needs of new enrollees whose current regimens include drugs that are not on the plan's formulary or those drugs that require prior authorization. You may find the appropriate formulary on the Producer Portal.

Highmark Senior Markets Medicare Products

Product Name	Available In (Products and Pricing by County)	НМО/РРО
Complete Blue	WPA	PPO
Together Blue Medicare	WPA	НМО
Community Blue Medicare	PA	HMO and PPO
Community Blue Medicare Plus	NEPA	PPO
Freedom Blue	PA, WV, DE	PPO
Security Blue	WPA	HMO-POS
Blue Rx PDP	PA, WV	PDP
Senior Blue	Western New York, Northeastern New York	НМО
Senior Blue Select	Western New York	НМО
BlueSaver	Western New York	НМО
Freedom Nation	Western New York, Northeastern New York	PPO
Forever Blue	Western New York, Northeastern New York	PPO
Freedom Basic	Northeastern New York	PPO
Freedom	Northeastern New York	НМО

Medigap

Medigap Blue plans help pay for costs that are not covered by Original Medicare, such as deductibles, coinsurance, and copayments. Medigap offers you a choice of eight plans: Plan A, B, C, D, F, F High Deductible, G, and N. With Medigap, you have the ability to choose any doctor, specialist, or hospital that accepts Medicare — with no limitations and no referrals. Like other Medicare Supplement plans, Medigap does not come with Part D prescription drug coverage. Please note that you cannot enroll in Plans C and F if turning 65 after Jan. 1, 2020.

In 2019, we added the Whole Health Balance program. This program allows members to add vision, hearing, dental, and fitness benefits to their Highmark Medigap Blue plan for an additional premium.

Medigap Blue Plan B is currently available only in Pennsylvania and Delaware. Medigap Pan D not available in New York. Whole Health Balance not available in New York. Not all plans are available in all regions.

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.
- Blue On CallsM: Highmark's health coaches are available 24/7 to answer general medical questions.
 - Help your clients understand a recent diagnosis, treatment options, or lab tests.
 - Review your clients' symptoms and help them decide where to receive care.
 - Ensure that your clients are taking medications properly.
 - Provide support for losing weight, managing stress, or quitting smoking.
 - Answer medical questions and provide information.

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

- AIS Home Visit Program: When dealing with a serious medical condition, we can provide an extra layer of support in your home to help you and your family throughout the course of your illness. Advanced Illness Services are available 24 hours a day, seven days a week to help your clients focus on what matters most to them. Learn more about the services provided by the AIS Home Visit Program by contacting 877-317-0216.
- Highmark House Call: Once a year, a licensed health care provider will come to your client's home to review their medications, answer healthrelated questions, and make sure their medical history is current.
- People Able to Lend Support (PALS): This volunteer program provides non-medical assistance to Highmark members in need. Volunteers are able to assist with everyday activities such as grocery shopping, household chores, yard work, light meal preparation, errands, and friendly phone calls or visits. To find out more about this program, please call 800-988-0706, 8:30 a.m. 4:30 p.m., Monday Friday.
- SilverSneakers®: This benefit provides access to fitness and wellness classes at health clubs across the country at no cost. Your clients can get fit, make friends, and live a healthier, more active life with this program. Clients will have access to over 14,000 facilities nationwide with cardio and weight equipment, pools, saunas, and exercise classes taught by certified senior fitness instructors. Call 888-423-4632 or visit SilverSneakers.com to take advantage of this valuable program.*
- Highmark Wellness Rewards Program: With our rewards program benefits, your clients can earn gift cards for taking positive actions that promote health and well-being.

^{*}Benefits vary by plan. Not all benefits available with all plans.

Value-Added Benefits

The **Mental Wellbeing** solution offers fast, expanded access to a network of high-quality mental health providers, using actionable data to deliver the right care for each member. This includes digital exercises, care navigation, coaching, therapy, medication management, and a 24/7/365 crisis support line. After enrolling, members are asked to complete an assessment that creates a care pathway based on their answers. Interventions range from self-guided activities to clinical appointments. This program is available to members 6 years and older, and offered to MA and ACA members as part of their medical benefits.

Well360 Virtual Health powered by American

Well is a virtual care solution that provides Urgent Care, Behavioral Health, Virtual Primary Care, Dermatology, and Women's Health services. Members will easily and seamlessly access the entire suite of Well360 Virtual Health practices through our fully integrated My Highmark/Beneficity experience. Well360 Virtual Health is available to MA and ACA members as a part of their medical benefits.

Benefits include:

- On-demand or scheduled appointments.
- Easy access to all practices via My Highmark and Beneficity apps and websites.
- 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.
- Smaller care gaps and faster-time-to-treatment options with Dermatology and Behavioral Health.

Kidney Care Management (Healthmap)

Your clients with CKD and ESRD have complex treatment plans that often result in high-cost utilization and poor member experience. This solution works to support your client 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 Healthmap Solutions (Healthmap) Kidney Care Management program. By enrolling, they'll 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.

CHF and COPD Management powered by Vida®*

CHF and COPD Management powered by Vida aims to help those with Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF) better manage their condition, reduce or avoid hospital admissions, readmissions, and ER visits. The virtual solution allows your clients to learn how to expertly recognize, manage and monitor their symptoms all while utilizing the help of registered dietitians, health coaches, in-app trackers, lessons on symptom monitoring, regular mental health assessments, and monitoring devices. When needed, a patient will have access to digital scales, blood pressure monitoring devices, digital scales, and respiratory tracking devices.

2024 Pharmacy Network Updates

	Preferred Network (Preferred Copay)	Standard Network
PA	giant costco weis CVS pharmacy PITE AID Walmart CANT.	Walgreens
wv	giant cosrco weis eagle CVS pharmacy Walmart CANT.	Walgreens RITE AID
DE	Walgreens PITE AID Walmart >	COSTCO COSTCO COSTCO PORTO COSTCO PORTO COSTCO PORTO COSTCO PORTO COSTCO PORTO COSTCO PORTO COSTCO COST
New York	Walmart : Chopper. Wegmans	♦ CVS pharmacy*

Out of Network

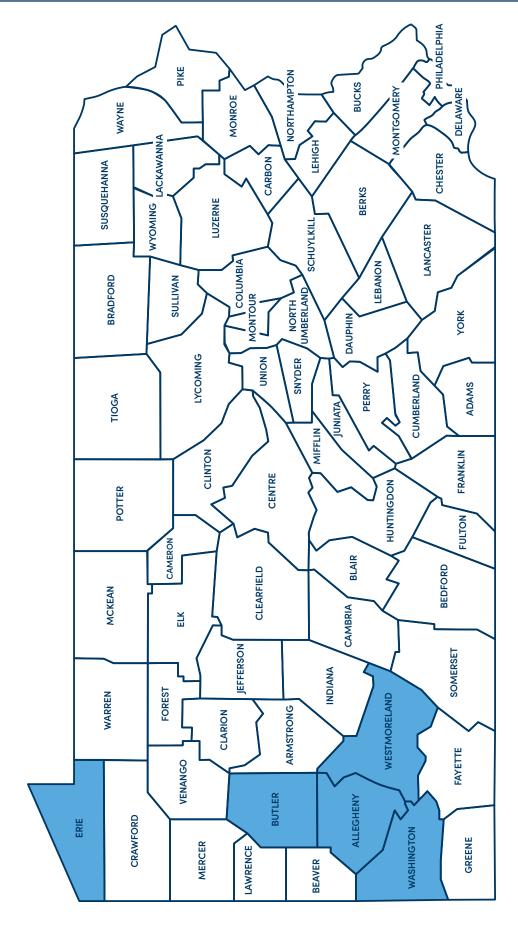
- Select specialty pharmacies
- Select independent pharmacies

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.

SECTION III: MEDICARE ADVANTAGE

Products and Pricing by County

Together Blue Medicare HMO — WPA



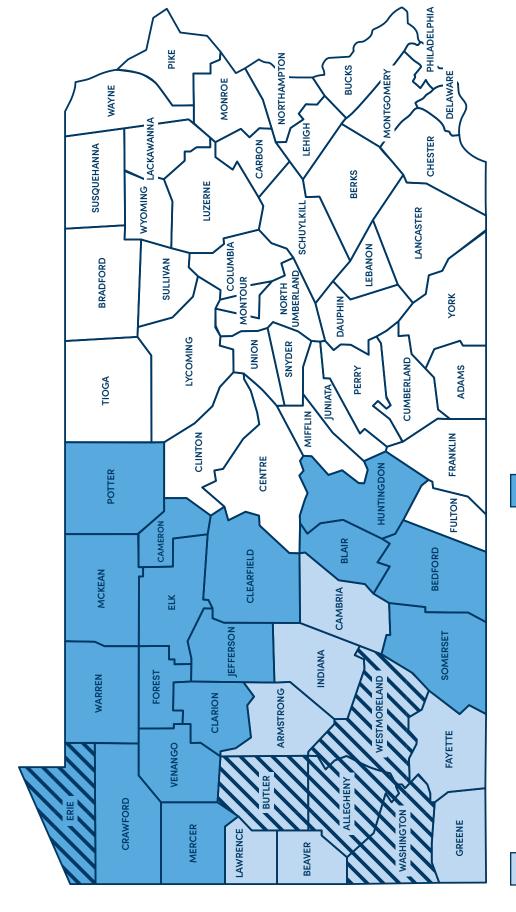
Together Blue Medicare HMO

*Pricing is subject to CMS approval

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

	a in principle
Monthly Plan Premium	08
Part B Premium Giveback	830
Out-of-Pocket Maximum	Network: \$5,900; Catastrophic: N/A
PCP Office Visit	\$0 Copay
Specialist Office Visit	SO Cobav
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	SO Copay
Lab and Diagnostic Tests (Outpatient Facility)	Constitution
X-Dove	\$0 Control
Radiation Therapy	\$60 Conay
Advanced I magina	S95 Copav
Preventive/Screening	Covered in Full (Office visit copay may apply)
Outpatient Physical and Speech Therapy	\$0 Copay
Medicare Covered Acubuncture	SOCopay
Outpatient Occupational Therapy	SOCopor
Outputient Mental Health	S30 Congress
Outpatient Substance Abuse	330 Copey
Outpatient Surgical	ASC: 595 Copov
	Facility: \$145 Cpay
Ambulance	\$275 Copay
Transportation	\$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.
Emergency Room	\$100 Copay
Urgent Care	\$30 Copay
spital Stay	C) Of Columbia
(COVID-19 cost share waiver has been removed)	NUMBER OF STREET
Inpatient Psychiatry Stay	\$325/day (days 1–3), \$0/day (days 4–90)
Skilled Nursing Facility	\$0/day (days 1–20); \$203/day (days 21–100)
Home Health	\$0 Copay
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are
	covered through a DMB supplied; confinedus glucose monitors, sensors and fransmirers aspensed via refail or mail order pharmacy, are limited to Abbott and Devorm 20%, crins errors for all other rowered diribative unalias
Durable Medical Fauipment	are illimical to Autorit and Descript, 20% Chinat rate for all office and added to applies.
	SAQ Allowance Once Date
Meal Benefit	Not Covered
Onduo	\$0 Onduo Virtual Diabetes Program
Spring Health	S0 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.
Fitness Benefit	Covered in Full
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin
Medicare Covered Vision (Office Visit)	\$0 Copay
Koutine Vision (Office Visit)	SU Copay (one every year)
Koufine Vision (Eyewear)	Standard eyeglass lenses and transe or contact lenses are covered in tull. A STUD benefit maximum applies to non-standard trames and a standard maximum for energical transmission of the contact of the contact representations.
Medicare Covered Hearing Exam	St. Const.
Politine Hearing Fram	SO Conny Compay
Routine Hearing Aids)	Two hearing aids every vear: TriHearing Advanced — \$669 conov.
Routine Dental	Office Visit: 50 Copov (one every six months) Includes exam, cleaning, and fluoride treatment. X-ray, 50 Copav (one every vear)
Medicare Covered Comprehensive Dental	SO Copy
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$1,500
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions,
	Non-Koutine Services, Diagnostics, Penadontics: US Coinsurance, See EUC for benefit limits.
Medicare Covered Chiropractic	SEE STEEL COPING
Modification Control De distant	(suspandados es
Medicare Covered rodiany Routine Podiatry	Sn Conny (I) visite)
ridiac and Pulmonary Rehab and SET.	(current forder or
Partial Hospital, Outpatient Blood	SO Copay
	Part D Drugs
Formulary	Lean (Performance)
Initial Coverage Period Limit: \$5,030. 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: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31 days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 2: \$120, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33%
Coverage Gap (Cost sharing is for up to 100-day supply for T and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply))	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
tastrophic OOP Threshold; \$8.000	The plan pays the full cost for covered Part D druas.
	565 5 2

Community Blue Medicare HMO — WPA



Community Blue Medicare HMO Greater Allegheny/Erie

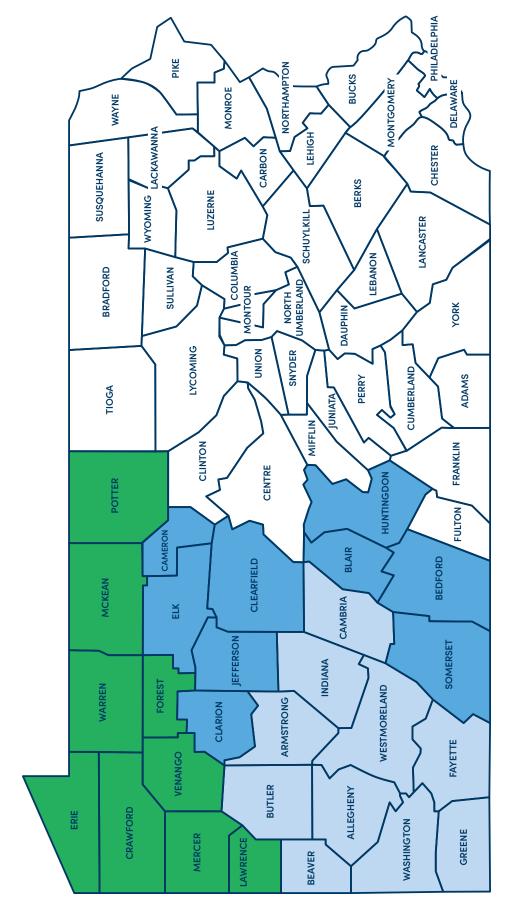
Community Blue Medicare HMO Southwest

Community Blue Medicare HMO West Central

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

	Signature	Prestige
Monthly Plan Premium	SW/WC/OW: \$0	SW: \$41
Part B Premium Giveback Out-of-Pocket Maximum	310 Network: SW/WC: \$5,500; OW: \$6,200; Catastrophic: N/A	Network: \$5,500; Catastrophic: N/A
PCP Office Visit	\$0 Copay	
Specialist Office Visit	SW/WC: \$20 Copay, OW: \$25 Copay	\$0 Copay
ab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay	\$0 Copay
Lab and Diagnostic Tests (Outpatient Facility)	SW/WC: \$0 Copay; OW: \$30 Copay	\$0 Copay
X-Rays	\$20 Copay	\$20 Copay
Radiation Therapy	\$60 Copay	S50 Copay
Advanced Imaging	SIBS Copay	Sas Copay
Preventive/ Screening Output and Descript Thomas		Covered in Full (Unice visit copay may apply)
Medicare Covered Action of the	SW/WC: \$20 Copay; OW: \$30 Copay	SIO Copay
Outpatient Occupational Therapy	SW/WC: \$20 Copay; OW: \$30 Copay	\$10 Copay
Outpatient Mental Health	\$40 Cobay	\$30 Copav
Outpatient Substance Abuse	\$45 Cobay	\$30 Copay
Outpatient Surgical	ASC: SW/WC: \$175 Copay; OW: \$195 Copay; Facility: \$245 Copay	ASC: \$75 Copay, Facility: \$150 Copay
Ambulance	\$275 Copay	\$175 Copay
Transportation	\$0 Copay. Covered only if trip is part of con	ntinued acute care after discharge from E
Emergency Room	\$100	Copay
Urgent Care	\$50 Copay	\$20 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	SW/WC: \$250/admid; OW: \$295/admit	\$200/admit
Inpatient Psychiatry Stay	\$425/day (days 1–3), \$0/day (days 4–90)	\$225/admit
Skilled Nursing Facility		\$0/day (days 1–20); \$203/day (days 21–100)
Home Health	\$00\$	Сорау
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy a	nsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous e monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies.
Durable Medical Equipment	20% Coin	20% Coinsurance
отс	SW: \$100/WC: \$105/OW: \$80 Allowance Once Per Quarter	\$75 Allowance Once Per Quarter
Onduo	\$0 Onduo Virtual [\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral hea	80 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart	\$0 program for COPD and congestive hear! failure to manage condition through an app.
eathcare Kits	Not Covered	Not Covered
Timess Denemin	deriver of the paraver actives	ed in ruil the Consulisted for outpastiont
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99% Coinsurance for Part B rebatable druc	as and 20% Coinsurance for all other Part B druas
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$3	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin
Medicare Covered Vision (Office Visit)	SW/WC: \$20 Copay, OW: \$25 Copay	\$0 Copay
outine Vision (Office Visit)	\$0 Copay (on	ne every year)
Koufine Vision (Eyewedr)	Standard e/eglass lenses and traines or condart lenses are covered in tull. A stud benefit standard e/mediate maximum applies to non-standard frames and a \$100 benefit maximum for specialty maximum contact lenses. \$200 benefit maximum for post cataract eye-wear, I.N. contact lenses. \$200 benefit maximum for post cataract eye-wear, I.N.	Standard eyeglass lenses and trames of contact lenses are covered in full. A stab benefit maximum applies to non-standard trames and a \$150 benefit maximum for specialty contact lenses, \$200 benefit maximum for post cataract eyewear. IN
Medicare Covered Hearing Exam	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay
Routine Hearing Exam	SW/WC: \$20 Copay (one every year); OW: \$25 Copay (one every year)	\$0 Copay (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year; TruHearing Advanced — \$699 copay;	Two hearing aids every year; TruHearing Advanced — \$499 copay;
Routine Dental	Office Visit: \$0 Copay (one every six months) Includes exam. cleaning. and fluoride	Office Visit: \$0 Copay (one every six months) Includes exam. cleaning, and fluoride
	treo	treatment. X-ray: \$0 Copay (one every six months)
Medicare Covered Comprehensive Dental	SW/WC: \$20 Copay, OW: \$25 Copay	\$0 Copay
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000	Combined maximum allowance of \$3,500
Comprehensive Dental - Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance. See EOC for benefit linnis.	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance. See EOC for benefil limits.
Medicare Covered Chiropractic	SW/WC; \$20 Copay; OW; \$15 Copay	\$10 Copay
outine Chiropractic	SW/WC: \$20 Copay (four visits); OW: \$15 Copay (four visits)	\$10 Copay (eight visits)
Medicare Covered Podiatry	SW/WC: \$20 Copay; OW: \$25 Copay	\$0 Copay
Routine Podiatry	SW/WC: \$20 Copay (four visits); OW: \$25 Copay (four visits)	\$0 Cop
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood		\$0 Copay
	Part D Drugs	
Formulary	Lean (Performance)	Base (Venture)
Initial Coverage Period Limit: \$5,030, Refail: Cost sharing is for up to 31-day supply. Can get up to 100-days supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Speciality Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$40, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a	Prefered Mail Order: Tier 1: 80, Tier 2: 80, Tier 3: \$120,	Prefered Mail Order: Tier1: \$0, Tier 2: \$0, Tier 3: \$92.50,
o-day supply for to died 14, except opening fier (up to other).	Standard Mail Order: Tert: 527, Tier 2: 545, Tier 3: 5141, Tier 4: 5300, Tier 5 (31-day supply): 33%	Standard Mail Order: Tier 1: \$15, Tie 2: \$57, Tier 3: \$14, Tier 4: \$300, Tier 5 (31-day supply): 33%
Coverage Gap (Cost sharing is for up to 100-day supply for Intand T2 and up to a 90-day supply for T3 and T4, excet Specialty tier (up to 31-days supply)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Preferred Mail: Preferred Generics: Tier 1(\$0) Generics: Tier 2(\$0); Standard Mail: Preferred Generics: Tier 1(\$1) Generics: Tier 2(\$57); Generics: Tier 3-5 (\$75);
Catastrophic OOP Threshold: \$8,000	The plan pays the full cost	The plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a	Tier 3 Insulin: \$20 for 31-day supply and \$60 for 90-day supply at a retail or mail order
	The state of the s	hobarmacy. Tier 4 has lin: \$35 for 31-day supply and \$105 for 90-day supply at a retai

Complete Blue PPO — WPA



Complete Blue PPO West Central

Complete Blue PPO Southwest

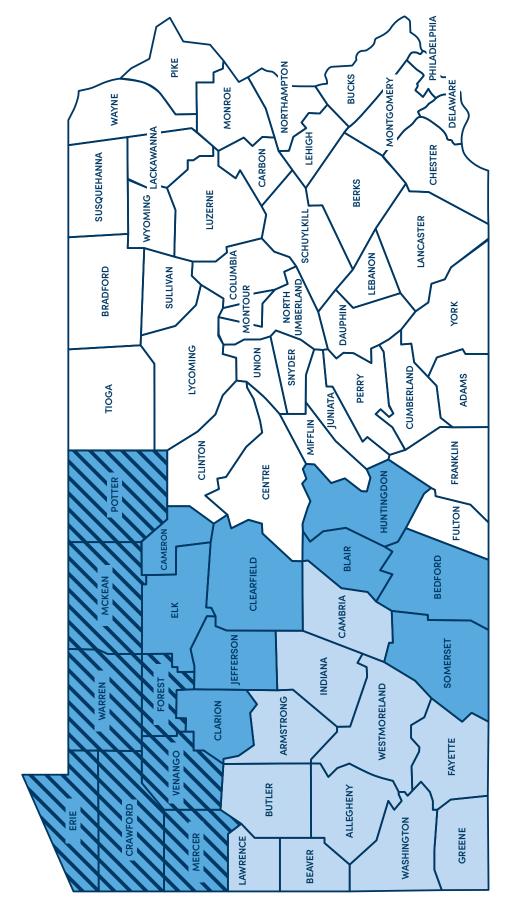
Complete Blue PPO Northwest

*Pricing is subject to CMS approval

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

Monthly Plan Premium	SW/WC: \$0	NW: \$0	SW/WC/NW: \$27	\$46
	0.00	010	C.	
Part B Premium Giveback Out-of-Pocket Maximum	\$10 Network: \$6,500; Catastrophic: \$8,950	\$10 Network: \$6,500; Catastrophic: \$8,950	\$0 Network: \$5,500; Catastrophic: \$9,550	\$0 Network: \$4,900; Catastrophic: \$8,950
PCP Office Visit		N N) 0\$	
becialist Office Visit	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON	\$0 Copay IN; \$0 Copay OON
b and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Lab and Diagnostic Tests (Outpatient raciiity) X-Rovs	\$0 Copay IN; \$25 Copay OON	S20 Copay IN; S30 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON
Radiation Therapy		\$60 Copay IN; \$90 Copay OON	\$50 Copay IN; \$50 Copay OON	\$50 Copay IN; \$50 Copay OON
AdvancedImaging		\$195 Copay IN; \$300 Copay OON	\$175 Copay IN; \$175 Copay OON	\$150 Copay IN; \$150 Copay OON
Preventive/Screening		Covered in Full (Office visit	copayı	
tpatient Physical and Speech Therapy	\$20 Copay IN; \$35 Copay OON	\$20 Copay IN; \$30 Copay OON	S5 Copay IN; S5 Copay OON	\$0 Copay IN; \$0 Copay OON
Medicare Covered Acupanicinie Outpatient Occupational Therapy	\$30 Copay IN; \$30 Copay OON	S30 Copay IN; S60 Copay OON	S30 Copay IN; S40 Copay CON	SO Copay IN: SO Copay OON
Outpatient Mental Health	SAO Coppy IN: \$50 Coppy OON	SAO Copay IN: S60 Copay OON	SAO Copay IN: SAO Copay OON	S30 Copay IN: S30 Copay OON
Outpatient Substance Abuse	\$45 Copay IN; \$50 Copay OON	\$45 Copay IN; \$60 Copay OON	\$45 Copay IN; \$50 Copay OON	\$30 Copay IN; \$30 Copay OON
Outpatient Surgical	ASC: \$195 Copay IN; \$325 Copay OON		ASC: \$175 Copay IN; \$175 Copay OON	101
	Facility: \$245 Copay IN; \$375 Copay OON	Facility: \$225 Copay IN; \$350 Copay OON	\$225 Copay IN; \$350 Copay OON Facility: \$200 Copay IN; \$200 Copay OON	: \$200 Copay IN
Ambulance	. 0 800 141	Emergent/Non-Emergent: \$275 IN;	Non-Emergent: 30% Coinsurance OON	. 0 800 111
nsportation	50 Copay IN; 30% Consurance OON. Covered only if trip is part of continued	50 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute	50 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued
	acute care after discharge from ER.	acute care after discharge from ER.	care after discharge from ER.	acute care after discharge from ER.
Emergency Room			\$100 Copay	7353
Urgent Care	San Copal		san Copay	sis Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$150/day (days 1-3) IN, \$0/day (days 4-90) IN; \$300/day (days 1-3), \$0/day (days 4-90) OON	\$250/admit IN; \$475/admit OON	\$225/admit IN; \$225/admit OON	\$225/admit IN; \$225/admit OON
Inpatient Psychiatry Stay	\$425/day (days 1-3), \$0/day (days 4-90) IN;	_	\$425/day (days1-3), \$0/day (days4-90) IN; \$425/day (days1-3), \$0/day (days4-90) IN;	\$300/admit IN: \$300/admit OON
Skilled Numeira Earlitte	\$4/5/day (days 1–3), \$0/day (days 4–90) OON	_	\$4/5/day (days 1-3), \$0/day (days 4-90) OON	
Home Health		SO Copey IN: 30	SO Copay IN: 30% Coinsurance OON	
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received v	via retail or mail order pharmacy limited to Abbo	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors,	gha DME Supplier; continuous glucose monitor
Durable Medical Fauitoment	ole Loris della li diligia di persed vid rela	all of mail order pridimacy are illilled to abboil a	20% Coinsurance IN: 30% Coinsurance OON	diabelic supplies. In, 30% Collisar diree CON
OTC	\$105 Allowance Once Per Quarter IN	\$130 Allowance Once Per Quarter IN	\$200 Allowance Once Per Quarter IN	\$120 Allowance Once Per Quarter IN
Onduo		\$0 Onduo Virtuo	\$0 Onduo Virtual Diabetes Program	
Spring Health		\$0 behavioral h	\$0 behavioral health care program	
CHF and COPD Management powered by Vida		Sovered in Full IN: 50% Coincurance	Trailure to manage condition inrough an app.	
Additional Telehealth Services		Services covered with applic	Services covered with applicable Copay listed for outpatient	
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99% C	Coinsurance for Part B rebatable drugs and 20%	0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	surance OON
Part B Drugs — Insulin	20%(Coinsurance up to a maximum of a \$35 copay fo	a one month supply of insulin IN; 30% Coinsurance	NOO
Medicare Covered Vision (Office Visit) Routine Vision (Office Visit)	szu copay III, szu capay COIN	SO Copay IN; SZU Copay IN; SSO Cop	av OON (one every vegr)	so copay in; so copay con
Routine Vision (Eyewear)	Standard eyeglass lenses and frames or conto	act lenses are covered in full. IN/OON: A \$150 ber	nefit maximum applies to non-standard frames and	d a \$150 benefit maximum for specialty contac
	MOO THE TOTAL PROPERTY OF THE	lenses. \$200 benefit maxim	num tor post cataract eyewear.	NO CONTRACTOR OF THE PROPERTY
Medicale Covered nearing Exam Routine Hearing Exam	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	S2C Coppy ON S2C Coppy IN S2C Copp	so Coppay In, so Coppay CON
	(one every year)	(one every year)	sto copay in, sto copay con (one every year)	so copay III, so copay CON (one every year)
Koutine Hearing (Hearing Alds) Routine Dental	Iwo hearing a	aids every year, TruHearing Advanced — \$699 co it: \$0 Conav IN: 30% Coinsurance OON fone ever	Iwo hearing aids every year, Iruhearing Advanced — \$699 copay, Iruhearing Premium — \$999 copay IN; \$500 allowance C Office Visit: \$0 Copay IN: 30% Chins irance OON (one every six months) Inclindes evam cleaning and fluoride treatment	allowance OON e treatment
		X-ray: \$0 Copay IN; 30% Coi	nsurance OON (one every year)	
Medicare Covered Comprehensive Dental	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON	\$0 Copay IN; \$0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2,500	Combined maximum allowance of \$2,500		Combined maximum allowance of \$3,000
prehensive Dental — Supplemental	Restorative Services, Endodontics, Prostho Extractions, Non-Routine Services, Diagr 50% Coinsurance OON. S	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 20% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endadontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN.	Restorative Services, Endodontics, Prosthadontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See
	MOC PCS -INI	MOO 0000 - MI		EOC for benefit limits.
Medicare Covered Chiropractic	S15 Copay IN; \$35 CODN (four vieite)	S15 Copay IN; \$30 OON	\$15 Copay IN: \$15 Copay ON (four vieits)	\$20 Copay IN; \$20 Copay OON
Medicare Covered Podiatry	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON	\$0 Copay IN; \$0 Copay OON
Routine Podiatry	\$20 Copay IN; \$20 Copay OON (four visits)	\$20 Copay IN; \$20 Copay OON (four visits)	\$10 Copay IN; \$10 Copay OON (four visits)	\$0 Copay IN; \$0 Copay OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood			\$0 Copay IN; 30% Coinsurance OON	
-		Part D Drugs	9	
Formulary		Lean (Performance)	Lean (Performance)	Base (Venture)
nniar Coverage retroa Limin. 3,5,50x, ettemic. Cost starings is to up to 31-day supply. Can get up to 100-day supply for 11 and 12 and 90-day supply for 13 and 14 at 3x copay, except Specialty Tier 5.	Trer s: \$47, Tier 4: \$00, Tier 5: \$3% Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47 Tier 4: \$500, Tier 5: 32%	Treferred Keldir. Her 1. 30, 1ref 2. 30, Tier 3. 547, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 5: 647 Tier 4: \$500 Tier 6: 33%	Treferred Refair. 1810, 1181 2.30, Tier 3: \$42, Tier 4: 5100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: \$47 Tier 4: \$400, Tier 6: 33%	Treferred Refair. 1801, 11er 2: 30, Tier 3: 342, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 5: 547 Tier 4: \$400 Tier 6: 33%
Mail Order: Cost sharing is for up to 100-day supply for	Preferred Mail: Tier 1: 50.0 Tier 2: 50,	Preferred Mail: Tier 18, 20, Tier 2, 50, Tiez 2, 6400 Tiez 4, 6775 Tiez 5, 20%	Preferred Mail: Tier 1: 50.0 Tier 2: 50, Tier 3: 50, Tier 3: 50, Tier 5: 50, T	Preferred Mail Tier 1: 50, Tier 2: 50, Tier 2: 50, Tier 3: 540, Tier 4: 500 Tier 5: 50,
ina iz ana up 10 a so-aay supply 101 is ana 14, except scialty fier (up to 31-days supply)	Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%	Standard Mail: Tier1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%	Standard Mail: Tier 1: \$20, Tier 2: \$60, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%	Standard Mail: Tier 1: \$200, Tier 2: \$50, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%
Coverage Gap (Cost sharing is for up to 100-day supply forT1 and T2 and up to 490-day supply for T3 and T4, excent Specialty tier (up to 31-days supply))		Generics (25% coinsurance) Brand (;	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	
tastrophic OOP Threshold: \$8,000		The plan pays the full co	The plan pays the full cost for covered Part D drugs.	
Land CO. 14				

Security Blue HMO-POS — WPA



Security Blue HMO-POS West Central

Security Blue HMO-POS Other West Central

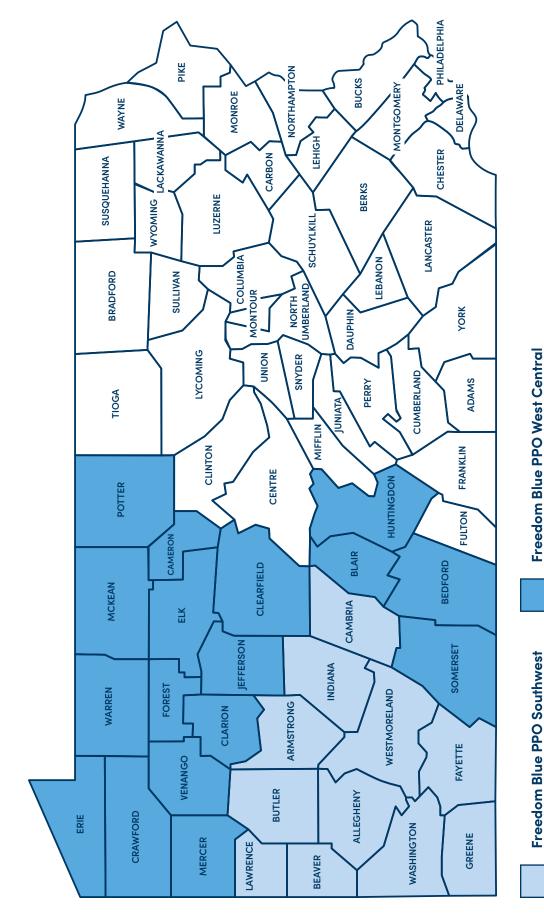
Security Blue HMO-POS Southwest

*Pricing is subject to CMS approval

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

SW. SAB, WC SOCRETOR TWO he SOCRETOR SOCRETOR TWO he SOCRETOR SOCRETOR SOCRETOR SOCRETOR SOCRETOR SOCRETOR SOCRETOR TWO he SOCRETOR SOCRET	2. Su Copay POS 3. Su Su Copay POS 3. Su Su Su	Swi. 546; WC: 543; OW: 543; WC: 540; WC: 543; OW: 544; WC: 55,500; Catastrophic: 39,950 Network: 55,500; Catastrophic: 39,950 SiO Copay IN; SiO Copay	SW: \$182, WC: \$148 Network: \$5,000, Catastrophic: \$9,950 \$0 Coppy IN; \$0 Coppy POS \$30 Coppy IN; \$30 Coppy POS \$10 Coppy IN; \$15 Coppy POS \$10 Coppy IN; \$15 Coppy POS \$10 Coppy IN; \$15 Coppy POS \$20 Coppy IN; \$15 Coppy POS	SW: \$245; WC: \$209 Network: \$4,500; Catastrophic: \$8,950 \$0 Copay IN; \$0 Copay POS \$25 Copay IN; \$15 Copay POS \$0 Copay IN; \$15 Copay POS
So Copay IN; 530 S25 Copay IN; 546 S25 Copay IN; 530 Copay IN;	Copay POS 830 Copay POS 830 Copay POS 830 Copay POS 840 Copay POS 845 Copay POS 846 Copay POS 846 Copay POS 847 Copay 847 Copay 848 Copay POS	NewWork's 5,200	Network: Sycholy, Carastrophic: 36, 150 SO Copay IN; SO Copay POS SO Copay IN; SIS Copay POS SIO Copay IN; SIS Copay POS SIO Copay IN; SIS Copay POS SIO Copay IN; SIS Copay POS	Network: 34,500; Cafastrophic: 36,950 \$0 Copay IN; \$0 Copay POS \$25 Copay IN; \$25 Copay POS \$0 Copay IN; \$15 Copay POS
San Copay IN; 330 Copay IN; 330 Copay IN; 330 Copay IN; 330 Copay IN; 345 San Copay IN; 350 Copay IN	330 Copay POS 330 Copay POS 330 Copay POS 340 Copay POS 341 Copay POS 341 Copay POS 342 Copay POS 342 Copay POS 343 Copay POS 344 Copay POS 345 Copay POS 346 Copay POS 347 Copay POS 347 Copay POS 347 Copay POS 348 Copay POS 348 Copay POS 358 Copay POS 35	S40 Copay IN; \$30 Copay PCS \$40 Copay IN; \$35 Copay POS \$50 Copay IN; \$25 Copay POS \$20 Copay IN; \$25 Copay POS \$20 Copay IN; \$25 Copay POS \$20 Copay IN; \$25 Copay POS \$175 Copay IN; \$25 Copay POS \$40 Copay IN; \$45 Copay POS \$50 Copay IN; \$45 Copay POS \$60 Copay IN; \$60 Copay I	830 Coppay IN; \$3 Coppay POS \$30 Coppay IN; \$31 Coppay POS \$10 Coppay IN; \$15 Coppay POS \$20 Coppay IN; \$15 Coppay POS \$20 Coppay IN; \$15 Coppay POS	su copay IN; su capay POS \$25 Copay IN; \$25 Copay POS \$0 Copay IN: \$15 Copay POS
\$100 Copay IN; \$300 S20 Copay IN; \$300 S20 Copay IN; \$45 S30 Copay IN; \$45 S30 Copay IN; \$45 S30 Copay IN; \$45 S45 S30 Copay IN; \$45 S45 S30 Copay IN; \$390 S340/admit IN; \$390 S30 Copay IN; \$300 Copay IN; \$300 S30 C	\$30 Copay POS \$40 Copay POS \$40 Copay POS \$45 Copay POS \$46 Copay POS \$4	80 Coppay INI, \$25 Coppay POS \$20 Coppay INI, \$25 Coppay POS \$20 Coppay INI, \$25 Coppay POS \$20 Coppay INI, \$225 Coppay POS \$175 Coppay INI, \$225 Coppay POS \$40 Coppay INI, \$45 Coppay POS \$40 Coppay INI, \$45 Coppay POS \$40 Coppay INI, \$250 Coppay POS \$40 Coppay INI, \$45 Coppay POS \$40 Coppay INI, \$450 Coppay POS \$40 Coppay INI, \$450 Coppay INI, \$450 Coppay POS	\$0 Copay IN; \$15 Copay POS \$10 Copay IN; \$15 Copay POS \$20 Copay IN; \$35 Copay POS	\$0 Copay IN: \$15 Copay POS
\$20 Copay IN; \$30 Copay IN; \$45 is \$30 Copay IN; \$200 Copay IN;	S30 Copoy POS S40 Copoy POS S45 Copoy POS S46 Copoy POS S47 Copoy POS S48 Copoy POS S58 Copoy POS S5	\$20 Copay IN; \$25 Copay POS \$20 Copay IN; \$25 Copay POS \$20 Copay IN; \$25 Copay POS \$175 Copay IN; \$25 Copay POS Covered in Full (Office Notes of N	\$10 Copay IN; \$15 Copay POS \$20 Copay IN: \$35 Copay POS	
\$25 Copay IN; \$40 (\$100 Copay IN; \$45 (\$30 Copay IN; \$45 (\$330 Copay IN; \$45 (\$330 Copay IN; \$45 (\$100 Copay IN; \$45 (\$100 Copay IN; \$45 (\$100 Copay IN; \$125 Copay IN; \$125 Copay IN; \$340 Copay IN; \$340 (\$100 Copay IN; \$340 Copay IN; \$340 Copay IN; \$350 Copay I	\$40 Copay POS \$175 Copay POS \$45 Copay POS \$45 Copay POS \$184 S20 Copay POS \$184 S20 Copay POS \$184 S20 Copay POS \$184 S20 Copay POS \$185 S20 Copay POS \$185 S20 Copay POS \$185 S20 Copay POS \$185 Copay	\$20 Copay IN; \$25 Copay POS \$60 Copay \$175 Copay IN; \$225 Copay POS Covered in Full (Office) \$40 Copay IN; \$45 Copay POS \$40 Copay IN; \$45 Copay POS ASC: \$175 Copay IN; \$25 Copay POS FOR SITS Copay IN; \$250 Copay POS SW: \$256 Copay IN; \$250 Copay IN SW: \$250 Copay IN; \$250 Copay IN	\$20 Copav IN: \$35 Copay POS	\$10 Copay IN; \$15 Copay POS
\$30 Copay IN; \$175 \$30 Copay IN; \$45 \$30 Copay IN; \$45 \$30 Copay IN; \$30 \$200 Copay IN; \$390 \$340/admit IN; \$300 \$340/admit IN; \$300 \$340/admit IN; \$300 \$340/admit IN; \$300 \$350/admit IN; \$300/admit IN	5.9175 Copay POS 5.45 Copay POS 5.45 Copay POS 1N; 5250 Copay POS 1N; 5250 Copay POS 20pay IN 50 Copay Copay 1N 50 Copay 1S390/admit POS 1S390	\$60 Copay \$175 Copay IN; \$225 Copay POS Covered in Full (Office) \$40 Copay IN; \$45 Copay POS \$40 Copay IN; \$45 Copay POS ASC: \$175 Copay IN; \$25 Copay POS Facility: \$200 Copay IN; \$250 Copay POS SW: \$256 Copay IN; \$250 Copay IN SW: \$256 Copay IN; \$250 Copay IN SW: \$256 Copay IN; \$250 Copay IN SW: \$250 Copay IN; \$250 Copay IN SW: \$250 Copay IN; WC/OW: \$275 Copay IN	the state of the s	\$15 Copay IN; \$30 Copay POS
\$30 Copay IN; \$1/5 \$30 Copay IN; \$45, \$30 Copay IN; \$45, \$30 Copay IN; \$45, \$45, \$45, \$45, \$45, \$45, \$45, \$45,	191/5 Copay POS 1845 Copay POS 1845 Copay POS 18, 2250 Copay POS 19, 2250 Copay POS 20pay IN \$250 Copay POS 20pay IN \$0 Cop 20	S1/3 Cappay IN; 3:22a Cappay PLOS S40 Cappay IN; 3:45 Cappay PLOS S40 Cappay IN; 5:45 Cappay POS S40 Cappay IN; 5:45 Cappay POS ASC: 5:175 Cappay IN; 3:250 Cappay POS FOCIETY S200 Cappay IN; 3:250 Cappay POS SW: 5:266 Cappay IN; WC/OW: 5:275 Cappay IN BY IN. Up to 2:4 One-way trips. Trip limit waived	S60 Copay IN; S75 Copay POS	
\$30 Copay IN; \$45, \$30 Copay IN; \$45, \$30 Copay IN; \$28 ASC; \$100 Copay IN; \$200 Copay IN; \$200 Copay IN; \$200 Copay IN; \$390 Copay IN; \$300	1845 Copoy POS 1845 Copoy POS 1N; \$250 Copoy POS 20 Copoy POS 20 Copoy IN 30 Copoy IN 30 Copoy 390 Codmit POS 3990 codmit POS 3990 codmit POS 3900 codmit POS	\$40 Copay IN; \$45 Copay POS \$40 Copay IN; \$45 Copay POS \$40 Copay IN; \$25 Copay POS Facility: \$200 Copay IN; \$256 Copay POS Facility: \$250 Copay IN; \$256 Copay POS SW: \$265 Copay IN; WC/OW: \$275 Copay IN BY IN: Up to 24 One-way trips. Trip limit waived SY Copay IN; WC/OW: \$275 Copay IN SY COPAY IN; WC/OW: \$275 CO	\$125 Copay IN; \$175 Copay PUS	\$75 Copay IN; \$125 Copay PUS
S30 Copay IN; 345 S30 Copay IN; 345 ASC: S100 Copay IN; 345 S125 Copay S340/admit IN; 339 S30 Copay IN; S30 S15 Copay IN; S30 S15 Copay IN; S30 S30 Copay IN; S30	1845 Copay POS 1845 S250 Copay POS 1845 S250 Copay POS 20	\$40 Coppay IN; \$45 Coppay POS \$40 Coppay IN; \$45 Coppay POS ASC: \$175 Coppay IN; \$255 Coppay POS Facility: \$200 Coppay IN; \$256 Coppay POS SW: \$265 Coppay IN; WC/OW: \$275 Coppay IN ay IN: Up to 24 One-way trips. Trip limit waived	SO LAN (Aiddo Anii Andon iisi	
S30 Coppy IN; 545; Facility: \$200 Coppy IN; 585 Facility: \$200 Coppy IN; 585 S340/admit IN; \$390 and/or hypertension to handloor hypertension handloor hypertension handloor hypertension had handloor hypertension had handloor hypertension had had handloor hypertension had	1845 Copouy POS N 5280 Copouy POS N 5280 Copouy POS N 5280 Copouy POS S 5280 Copouy	\$40 Copay IN; \$45 Copay POS ASC: \$176 Copay IN; \$225 Copay POS Facility: \$230 Copay IN; \$230 Copay POS SW: \$265 Copay IN; WC/OW: \$275 Copay IN By IN. Up to 24 One-way trips. Trip limit waived ay IN. Up to 24 One-way trips.	\$30 Copay IN; \$35 Copay POS	\$25 Copay IN; \$30 Copay POS
ASC: STOO Coppy IN; SY STOO Coppy IN; SY STOO Coppy IN; SY STOO Coppy IN; SY	(1975) 111,3250 Copay POS (20pay INI,3250 Copay POS (20pay INI) \$0 Cop	ASC: STN Cappay IN; \$223 Cappay POS Facility: \$200 Cappay IN; \$250 Cappay POS SW: \$265 Cappay IN; WC/OW: \$275 Cappay IN BY IN. Up to 24 One-way trips. Trip limit waived sty IN. Up to 24 One-way trips. Trip limit waived	\$30 Copay IN; \$35 Copay POS	\$25 Copay IN; \$30 Copay POS
\$125 Copage \$340/admit IN; \$390 \$340/admit IN; \$390 \$340/admit IN; \$390 \$340/admit IN; \$390 \$330 Copay IN; \$30 \$310 Copay IN; \$	Copay IN \$0 Cop Copay (S390/admit POS (S390/ad	SW: \$265 Copay IN; WC/OW: \$275 Copay IN ay IN. Up to 24 One-way trips. Trip limit waived	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
S50 Copa S340/admit IN; S39G S340/admit IN; S39G S340/admit IN; S39G Coinsuran Not Cover Not Cover and/or Hypertension to h Condition S30 Copay IN; S30 Copay S30 Copay IN; S30 Copay S35 Copay IN; S30 Co	S00 Copay Copay S390/admit POS S390/admit POS Cdibelic supplies received- raidbelic supplies received- raidbelic supplies received- sovered S8 Medis/14 Dove	ay IN. Up to 24 One-way trips. Trip limit waived	\$200 Copay IN	\$150 Copay IN
\$50 Copa \$340/admit IN; \$390 \$340/admit IN; \$390 \$340/admit IN; \$390 \$340/admit IN; \$390 O% Coinsurance for dial sensors 20% Coinsuran Not Cover Not Cover (inh diabetes, COPD, cong and/or hypertension to he and/or hypertension to he and/or hypertension to he sand Copay IN; \$30 \$15 Copay IN; \$30 \$15 Copay IN; \$30 \$30 Copay IN; \$30 \$3	S390/admit POS (S390/admit POS) (S390/ad	212	Copay IN. Up to 24 One-way trips. Trip limit waived if trip is part of continued acute care after discharge from ER.	ge from ER.
\$340/admit IN; \$395 \$340/admit IN; \$396 \$340/admit IN; \$396 \$340/admit IN; \$397 O% Coinsuran Not Cover Not Cover Not Cover Not Cover Not Cover S30 Copay IN; \$30 \$15 Copay IN; \$30 \$15 Copay IN; \$30 \$15 Copay IN; \$30 \$15 Copay IN; \$30 \$30 Copay IN; \$	S390/admit POS (S390/admit POS) (S390/admit POS) (S390/admit POS) (S390/admit POS) (S390/admit POS) (S40/admit		\$100 Copay	
\$340/admit IN; \$390 \$340/admit IN; \$390 \$340/admit IN; \$390 \$30 Copay IN; \$30 \$30 Co	\$390/admit POS \$390/admit POS rdiabetic supplies received insors and transmitters dispetived issurance IN surrance IN surrance IN surrance IN surrance IN surrance IN	11 (20 0 0 1) 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 /	\$5 Copay	
0% Coinsurance for dial sensors 20% Coinsurar 20% Coinsurar Not Coven Not Coven and/or hypertension to h and/or hypertension to h condition Standard eyeglass le \$30 Copay IN; \$30 \$15 Copay IN; \$30 \$15 Copay IN; \$30 \$30 Copay IN;	(\$390/admit POS raibbelt supplies received- nsors and transmitters dispet surrance IN surrance IN covered 28 Medis/14 Days	\$220/day (days 1–5), \$0/day (days 6–90) IN; \$270/day (days 1–5), \$0/day (days 6–90) POS	\$335/admit IN; \$385/admit POS	\$210/admit IN; \$260/admit POS
O% Coinsurance for dial sensors 20% Coinsuran Not Coven Not Coven Not Coven inh diabetes, COPD, cong and/or hypertension to h condition Sign Copay IN; Sign Copay Sign Copay IN; Sign Copa	rdiabetic supplies received insors and transmitters dispersurance IN isurance IN 28 Medis/14 Days	\$220/day (days 1-5), \$0/day (days 6-90) IN;	225 / Admit IN: \$285 / Admit DOS	2007; WI :: wpz/0123
0% Coinsurance for diate sensors 20% Coinsuran Not Cover Not Congulia Aember Selected Healthc. And diabetes, COPD, congulated or hypertension to hand/or hypertension to hand/or hypertension to hand and or hypertension to hand and or hypertension to hand and or hypertension to hand and congulia. \$30 Copay IN;	r diabetic supplies received Insors and transmitters dispe surance IN Covered 28 Meals/14 Days	\$270/day (days1-5), \$0/day (days 6-90) POS		\$210. ddillin, \$200. ddillin r (5
Sensors Sensors Sensors 20% Coinsuran Not Coven Not Coven (the didbetes, COPD, cong and/or hypertension to h condition to S30 Copay IN; \$ Standard eyeglass le \$30 Copay IN; \$ Standard eyeglass le \$30 Copay IN; \$ S15 Copay IN; \$30 Copay S30 Copay IN; \$30 Copay S30 Copay IN; \$30 Copay S30 Copay IN; \$30 Copay IN	r diabetic supplies received insors and fransmitters dispersurance IN 28 Medis/14 Days	\$0/day (days 1–20); \$0	\$203/day (days 21–100) IN Copay IN	
20% Coinsuran Not Cover Not Cover and/or hypertated Health condition and/or hypertation to hypertation to had a sign Copay IN; \$ \$30 Copay IN; \$30 Copay IN	isurance IN Sovered 28 Medis/14 Days	ia retail or mail order pharmacy limited to Abb	octory in ottand LifeScan, all other brands are covered thn ed to Abbott and Dexcom .20% coinsurance for all	betic supplies received via retail or mail order pharmacy limited to Abbott and Lifescan, all other brands are covered through a DME Supplier; continuous glucose monitors, and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Descom 20%, consurance for all other covered diabetic supplies. IN
i de he de	pe pe	7	20% Coinsurance IN. SW Only — Healing at Ho	me: \$0 cost-share for DME up to a \$1,000 allowance
i h d demk (i th d d mb d		20% Coinsurance IN	once per calendar year within 90 Days of	once per calendar year within 90 Days of Discharge from Inpatient Acute Hospital IN Only
vith d	28 Meals/14 Days	Not Covered	SW Only — Healing at Home: \$0 cost-share for once per calendar year within 90 Days of	Only — Healing at Home: \$0 cost-share for 28 hours of non-skilled in home care related services once per calendar vear within 90 Davs of Discharae from Inpatient Acute Hospital IN Only
vith d		IN upon discharge from an inpatient hospital st	28 Meals/14 Days IN upon discharge from an inpatient hospital stay, inpatient hospital psychiatric stay, or SNF stay to the home to qualify	to the home to qualify.
vith dand		\$0 Onduo Virtu	\$0 Onduo Virtual Diabetes Program	
vith dand and and		\$0 behavioral	50 behavioral health care program	
	\perp	Su program for COPD and congestive ne	so program for COPD and congestive neart tailure to manage condition inrougn an app.	
		with diabetes, COPD, congestive heart failure, and/or hypertension to help manage their condition (MC only: Not Covered SW/OW)	with diabetes, COPD, congestive heart failure, and/or hypertension to help manage their	Member Selected Healthcare Kit for members with diabetes, COPD, congestive heart failure, and/or hypertension to help manage their condition
		Cove	ed in Full IN	
		Services covered with appl	icable Copay listed for outpatient	
	%66-61-%0 %0c	Coinsurance for Part B rebatable drugs and 20	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance POS	Sinsurance POS
		\$40 Cop ay IN; \$40 POS	\$30 Copav IN; \$30 POS	\$25 Copay IN; \$25 POS
		\$0 Copay II	\$0 Copay IN (one every year)	
\$30 Copay \$15 Copay \$30 Copay \$30 Copay \$30 Copay	ass lenses and frames or cor	tact lenses are covered in full. A \$175 benefit me	Standard eyeglass lenses and frames or contact lenses are covered in full. ASTS benefit maximum applies to non-standard frames and a \$175 benefit maximum for specialty contact lenses.	75 benefit maximum for specialty contact lenses.
\$30 \$15 Copay I \$15 Copay \$30 Copay 8 \$30 Copay	VIN: \$30 POS	\$40 Cop dv IN: \$40 POS	\$30 Copav IN: \$30 POS	\$25 Copav IN: \$25 POS
\$30 \$16 Cop ay 1 \$16 Cop ay 1 \$30 Copay 8 \$30 Copay 8			\$0 Copay IN (one every year)	
\$30 Copc \$15 Copcy IN; \$30 \$15 Copcy IN; \$30 \$30 Copcy IN; \$30	vo hearing aids every year II	Two hearing aids every year IN; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay	ing Premium — \$899 copay	Two hearing aids every year IN; TruHearing Advanced
\$30 Copc \$15 Copcy IN; \$30 \$15 Copcy IN (\$30 Copcy IN (\$30 Copcy IN (Office Visit: \$15 Cop av IN (one every six	Office Visit: \$15 Copay IN (one every six months) X-ray: \$15 Copay IN (one every year)	
\$15 Copay IN; \$30 \$15 Copay IN; \$30 \$30 Copay IN; \$30 \$30 Copay IN (6	iopay IN	\$40 Copay IN	\$30 Copay IN	\$25 Copay IN
\$15 Copay IN; \$30 \$15 Copay IN; \$30 \$30 Copay IN; \$30 \$30 Copay IN (6)		Nov	Covered	
\$30 Copay IN; \$38 \$30 Copay IN; \$38	\$30 Copay POS	\$15 Copay IN (six visite)	\$15 Copay IN; \$30 Copay POS	\$15 Copay IN; \$25 Copay POS
\$30 Copay IN (e	\$30 Copay POS	\$40 Copay IN; \$40 Copay POS	\$30 Copay IN; \$30 Copay POS	\$25 Copay IN; \$25 Copay POS
	N (eight visits)	\$40 Copay IN (eight visits)	\$30 Copay IN (10 visits)	\$25 Copay IN (12 visits)
		\$0 Copay IN; 3	\$0 Copay IN; 30% Coinsurance POS	
		Part D Drugs		
NotCover	overed	Lean (Performance)	Base (Venture)	Base (Venture)
Initial Coverage Period Limit's 5,030 Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 Not Covered and T2 and 90-day supply for T3 and T4 at 3x copay, except	overed	Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19,	Preferred Retail: N/A Standard Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$44. Tier 4: \$100. Tier 5: 33%	Preferred Retail: N/A Standard Retail: Tier 1: 50, Tier 2: \$13, Tier 3: \$42, Tier 4: \$100. Tier 5: 33%
Specialty Tier 5.		Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	900000000000000000000000000000000000000	200000000000000000000000000000000000000
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 fier (up to 31-days supply)		Prefered Mail Order (1-90-day supply): Tier 1: \$0, Tier 2: \$12, Tier 3: \$115, Tier 4: \$275, Tier 6 (31-day supply): 33% Standard Mail Order (1-90-day supply): Tier 1: \$15, Tier 2: \$15, Tier 3: \$14, Tier 4: \$300, Tier 6: \$13-day supply): 33%	Tier 1: S0, Tier 2: S32, S0, Tier 3: \$110, Tier 4: \$250, Tier 5: 33%	Tier 1: \$0, Tier 2: \$32,50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33%
Coverage Gap (Cost sharing is for up to 90-day supply except Specialty tier (up to 31-days supply))	Covered	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount	Generics: Tier 1 (\$0) Generics: Tier 2 (\$32.50) Generics Tiers 3–5 (25% coinsurance)
				Brand (25% coinsurance including 70% discount)
	overed		The plan pays the tull cost tor covered Part D drugs.	ngs.
Coverage Gap stages	overed	Tier 3 and Tier 4 Insulins: \$	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	ıt a retail or mail order pharmacy

Freedom Blue PPO — WPA

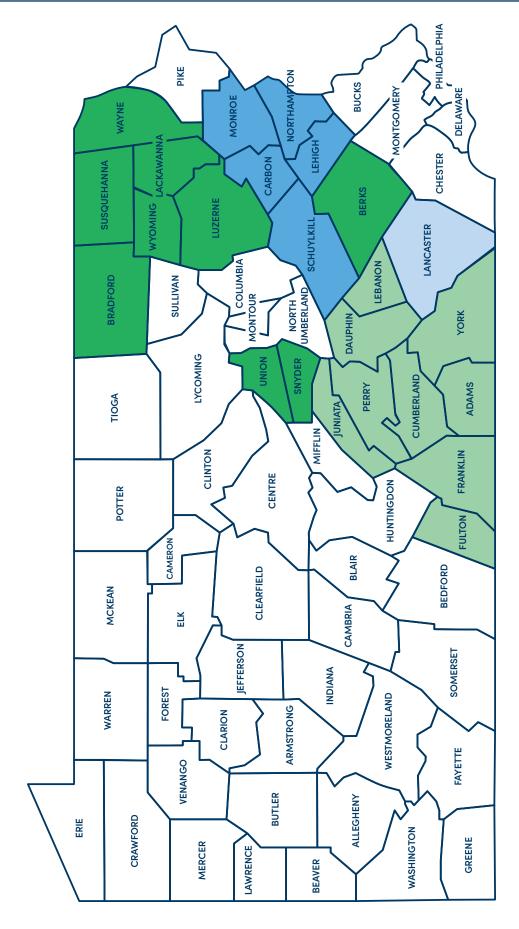


*Pricing is subject to CMS approval

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

Monthly Plan Premium Part B Premium Giveback Out-of-Packet Maximum PCP Office Visit Specialist Office Visit Lab and Diagnostic Tests (Phys. Office or Freestanding Lab) Lab and Diagnostic Tests (Outpatient Facility) X-Rays Readiation Therapy Advanced Imaging	SW: \$64; WC: \$61 \$0	SW: \$158; WC: \$119 \$0	SW: \$271; WC: \$243
Part B Frenchun Guveback Out-of-Pocket Maximum PCP Office Visit Specialist Office Visit Lab and Diagnostic Tests (Phys. Office or Freestanding Lab) Lab and Diagnostic Tests (Outpatient Facility) X-Rays Radiation Therapy Advanced Imaging		08	
Corn of the Visit Corporation of the Visit Corporation of the Visit Corporation of Corporation o	Materials: SE EOO: Output Line Se OFO	Natural: 65 000: Catastas Elias 69 050	Natural: 64 500: Catastrate N
Specialist Office Visit Lab and Diagnostic Tests (Phys. Office or Freestanding Lab) Lab and Diagnostic Tests (Outpatient Facility) K-Rays Rediation Therapy Advanced Imaging	SO Copay IN: SO Copay DON	SO Condy IN: SO Condy OON	SO Copay IN: SO Copay OON
Prestain Orner, train of the sets (Phys. Office or Freestanding Lab) Lab and Diagnostic Tests (Outpatient Facility) K-Rays Addingn Therapy Addingn Therapy	\$40 Copay IN: \$40 Copay OON	\$30 Copay IN: \$30 Copay OON	SSE Copay IN: \$25 Copay ON
cab and Diagnostic Tests (Curpatient Facility) 4-Rays Radiation Therapy Radiation Therapy		SO Copay IN: 330 Copay ON	SO Copay IN; \$10 Copay OON
G-Rays Advanced Imaging		S15 Copay IN: S15 Copay OON	S10 Copay IN: S10 Copay OON
tadiation Therapy Advanced Imaging	\$20 Copdy IN: \$20 Copdy OON	\$20 Copay IN: \$20 Copay OON	\$15 Copay IN: \$15 Copay OON
dvancedImaging		\$60 Copay IN; \$60 Copay OON	
	\$200 Copay IN; \$200 Copay OON	\$125 Copay IN; \$125 Copay OON	\$100 Copay IN; \$100 Copay OON
Preventive/Screening		Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical, Speech and Occupational Therapy,	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON	\$25 Copay IN; \$25 Copay OON
Modicar Coord American	MOO 2000 101 101 101 101 101 101 101 101 10	NOO 2000 IN: 630 Cos	NOO 35 NI METO 363
Outpotient Surgical	ASC: \$175 CODAY IN: \$175 CODAY	450 S125 Copay IN: \$125 Copay OON	ASC: 875 Copay IN: 875 Copay OON
	Facility: \$200 Copay IN; \$200 Copay OON	Facility: \$175 Copay IN; \$175 Copay OON	Facility: \$150 Copay IN; \$150 Copay OON
Ambulance	Emergent/Non-Emergent: \$275 IN; Non-Emergent: 30%	Emergent/Non-Emergent: \$215 IN;	Emergent/Non-Emergent: SW \$115 IN, WC \$165 IN;
	Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
Transportation	\$0 Copay IN; 30% Coinsurance OO	\$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	acute care after discharge from ER.
Emergency Room		\$100 Copay	
Urgent Care		\$5 Copay	
Inpatient Hospital Stay	\$220/day(days1–5), \$0/day (days 6–90) IN;	\$350/admit IN; \$350/admit OON	\$210/admit IN; \$210/admit OON
Inputient Psychiatry Stay	\$220/day(days1-5) \$0/day(days6-90)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 (days1–20); \$203/day (days 21–100) IN; 30% Coinsurance OON	7
Home Health Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mo	\$0 Copay IN; 30% Coinsurance OON il order pharmacy limited to Abbott and LifeScan, all other brands co	overed through a DME Supplier; continuous glucose monitors,
	sensors and transmitters dispensed via retail or mail order	itters 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	I other covered diabetic supplies. IN; 30% Coinsurance OON
Onduo		\$0 Onduo Virtual Diabetes Program	
Spring Health	**	\$0 behavioral health care program	-
CHF and COPD Management powered by Vida	\$U progra	30 program for COPD and congestive heart tailure to manage condition through an app. Not Covered	gn an app.
Durable Medical Equipment	. 0 200 111	SW: 20% Coinsurance IN; 30% Coinsurance OON; Healina at Home: \$0 cost-share for DME up to a \$1,000 allowance once per calendar	\$0 cost-share for DME up to a \$1,000 allowance once per calend
	ZO% COITISATIATICE IIN, 30% COITISATIATICE CON	year within 90 Days of Discharge from Inpatient Acute Hospi	Ital IN/OON. WC: 20% Coinsurance IN; 30% Coinsurance OON
Non-Skilled Care	Not Covered	SW: Healing at Home: \$0 cost-share for 28 hours of non-skille 0 Days of Discharge from Innationt Act	SW: Healing at Home: \$0 cost-share for 28 hours of non-ksilled in home care related services once per calendar year within n Dave of Discharce from Inputient Acres Howital INJON's WC: Not Covered
Meal Benefit	28 Meals/14 Days IN/OON upon disc	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	tay, or SNF stay to the home to qualify
Healthcare Kits		Not Covered	
FITNESS BENETIT		Covered in Full IN; 50% Coinsurdance dater satisfying a 5500 Deductible CON Services covered with applicable Conavileted for outpatient	NOC
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99% Coinsurance for	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	as 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, 30% Coinsurance OON	0% Coinsurance 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)	2
Rounne Vision (Eyewear)	olandara eyeglass lenses and Trames of comaci lenses are cover	and names of contact lenses are covered in full. IV CONY, a viz Determit maximum applies to non-standard frames and a viz Denetii maximum for post cafarogt evewear. \$200 benefit maximum for post cafarogt evewear.	irrames and a 5175 benetit maximum tot specially contact tenses.
Medicare Covered Hearing Exam		y IN; \$40 Copay OON \$30 Copay IN; \$30 Copay OON \$25 Copay IN	\$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)
outine Hearing (Hearing Aids)	Two hearing aids every year;	TruHearing Advanced - \$599 copay; TruHearing Premium - \$899 co	ppay IN; \$500 allowance OON
Routine Dental	Office Visit: \$15 Copay IN; 30% C	oinsurance OON (one every six months) X-ray: \$15 Copay IN; 30% Co	insurance OON (one every year)
Medicare Covered Comprehensive Dental Comprehensive Dental — Supplemental	\$40 Copay IN; \$40 Copay OON	\$30 Copay IN; \$30 Copay OON Not Covered	\$25 Copay IN; \$25 Copay UON
Medicare Covered Chiropractic	\$15 Copay IN: \$15 Copay OON	\$15 Copdy IN: \$15 Copdy OON	\$15 Copay IN: \$15 Copay OON
Routine Chiropractic		\$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 SE1, Partial Hospital, Outpatient Blood		\$0 Copay IN; 30% Coinsurance OON	
	Par	Part D Drugs	
Formulary	Lean (Performance)	Base (Venture)	Base (Venture)
Initial Coverage Period Limit: \$5,030. 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		Preferred Retail: Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	%% %
Mail Order: Cost sharing is for up to 100-day supply for Trand to and up to 90-day supply for T3 and T4, except Appeint vin to 31 dous supply)	Prefered M Standard M	Prefered Mail Order: Tier 1: S0, Tier 2: S27, Tier 3: S115, Tier 4: S275, Tier 5 (31-day supply): 33%. Standard Mail Order: Tier 1: S15, Tier 2: S57, Tier 3: S141, Tier 4: S300, Tier 5 (31-day supply): 33%.	y supply): 33% y supply): 33%
Coverage Gap (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 fier (up to 31-days supply))	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Preferred Mail: Preferred Generics: Tier 1 (\$0) Generics: Tier 2 (\$27); Standard Mail: Preferred Generics: Tier 1 (\$15) Generics: Tier 2 (\$57); Generics: Tier 3 - (\$28, doinstone) Brand (\$28, doinstone)
Catastrophic OOP Threshold: \$8,000		The plan pays the full cost for covered Part D drugs.	
IRA Benefits — T3 and T4 offered through ICP and	Tier 3 and Tier 4 Inst	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy	mailorderpharmacv

Community Blue Medicare HMO — CPA/NEPA



Community Blue Medicare HMO Northeast

Community Blue Medicare HMO Lehigh Valley

Community Blue Medicare HMO Harrisburg

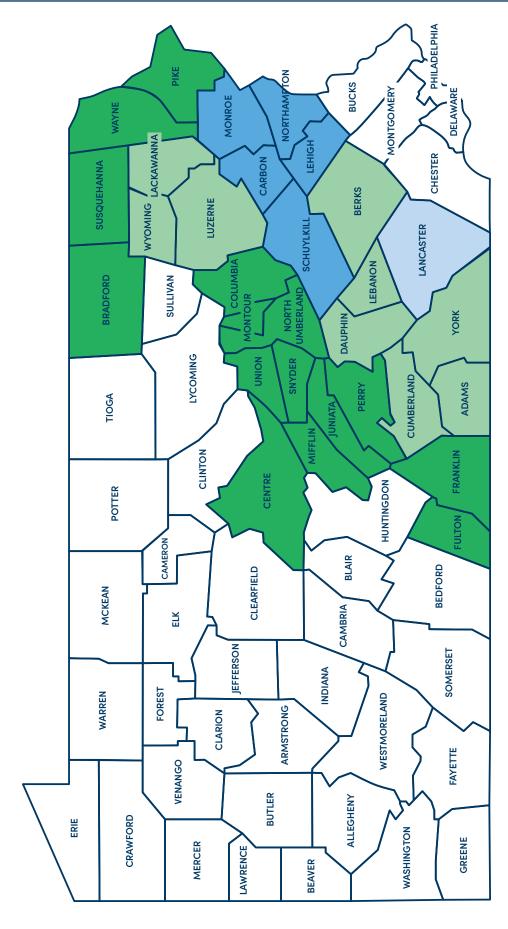
Community Blue Medicare HMO Lancaster

*Pricing is subject to CMS approval

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

	amplific	
Monthly Plan Premium	ıncaster: \$0	
Part B Premium Giveback		
Out-of-Pocket Maximum	Network: 86,500; Catastrophic: N/A	
PCP Office Visit	\$0 Copay	
Specialist Office Visit	\$0 Copay	
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay	
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay	
X-Rays	\$10 Copay	
Radiation Therapy	Agg Coba	
Advanced imaging Dravantive/Creaning	Conceed in Eull (Office or work and b)	
Outportient Physical and Speech Therapy	S20 Conny S20 Conny	
Medicare Covered Actions three	CV	
Outpatient Occupational Therapy		
Outpatient Mental Health	\$30 Copay	
Outpatient Substance Abuse	\$45 Copay	
Outpatient Surgical	ASC: \$125 Copay; Facility: \$175 Copay	Copay
Ambulance	\$250 Copay	
Transportation	\$0 Copay. Covered only if trip is part of continued acute care after discharge from ER.	
Emergency Room	\$100 Copay	
Urgent Care	\$0.Copay	
Inpatient Hospital Stay	timbe/05050	
(COVID-19 cost share waiver has been removed)		
Inpatient Psychiatry Stay	\$425/day (days 1-3), \$0/day (days 4-90) \$425/day (days 1-3), \$0/day (days 4-90)	s 4–90)
Skilled Nursing Facility	\$0/day (days 1–20); \$203/day (days 21–100)	
Home Health	\$0 Copay	
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a	Is are covered through a DME Supplier; continuous
Durable Medical Fauisment	glacose monitors, sensors and transminers arispensed via tetral or mail order primary for the properties of a monitors and provided the provided for the provid	ner covered didbello supplies.
	\$50 Allowance Once Der Olinter	rotr
Med Benefit	Parayo	
onpuO	\$0 Onduo Virtual Diabetes Program	
Spring Health	S0 behavioral health care program	
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.	
Healthcare Kits	Diabetes Only Healthcare Kit for members with type 1 and type 2 diabetes to help manage their condition.	
Fitness Benefit	Covered in Full	
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient	
Part B Drugs — Chemotherapy and All Other Part B	U%-19/29% Coinsurance for Part B rebatable drugs and 20% Coinsurance for fall other Part B drugs	
Modicare Covered Vision (Office Visit)	ZO.» Comisarance up to a maximum a copay for a one mornin supply of misalin	
Routine Vision (Office Visit)	S0 Copay (one every year)	
Routine Vision (Eyewear)	e covered in full. A \$150 benefit Standard eyeglass lenses and tenefit maximum applies to non-standard exceptions of the standard exception and the standard exceptions of the standard	e covered in full. A \$150 benefit enefit maximum for specialty
Modicare Covered Hearing Evam	5, إ	i calalaci eyewear.
Medicare Covered nearing Exam Porting Hearing Exam		
Routine Hearing (Hearing Aids)	2 Hearing Aids Every year, Truthearing Advanced — \$699 copay; 2 Hearing Aids Every year, Truthearing Advanced —	ced — \$699 copay;
Dough of Dough		opay
Kourine Denial	Unce vist: 9.0 Coppt (one every 8x months) includes skarin, cleaning, on and fluoride freatment, X-ray; 80 Coppy (one every 9x months) includes skarin, cleaning, on and fluoride freatment, X-ray; 80 Coppy (one every year)	luaes exam, cleaning, one every year)
Medicare Covered Comprehensive Dental	\$0 Copay	
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000	
Comprehensive Dental — Supplemental	Restorative Services, Endadonites, Prosthadonites, Other Oral/Maxilladatal Surgery Extractions, Non-Routine Services, Diagnostics, Periodonites: 0% Coinsurance. See ECC for benefit limits.	ntics: 0% Coinsurance.
Medicare Covered Chiropractic	\$10 Copay	
Routine Chiropractic	\$10 Copay (four visits)	
Medicare Covered Podiatry	\$0 Copay	
Routine Podiatry	\$0 Copay (four visits)	
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	SOCOPAY	
	sßr	
Pormulary	Lean (Performance)	
Initial Coverage Ferraa Limit: 35,330. Kerali: 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 174 at 38, coppy, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$4, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	
Mail Order: Cost sharing is for up to 100–day supply for T1 and T2 and up to a 90–day supply for T3 and T4, except Specially tier (up to 31 days supply)	Preferred Mail Order. Tier 1: \$0, Tier 2: \$0, Tier 2: \$0, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order. Tier 1: \$1, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33%	
Coverage Gap (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	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	
up to st-adys supply)) Catastrophic OOD Threshold: \$8,000	The nieu move the full cost for covered Port Diffune	
IDA Benefits — T3 and T4 offered through ICP and	me prioritoria no covered rom dos.	
	The state of the s	

Community Blue Medicare PPO Signature — CPA/NEPA



Community Blue Medicare PPO Signature Northeast

Community Blue Medicare PPO Signature Lancaster

*Pricing is subject to CMS approval

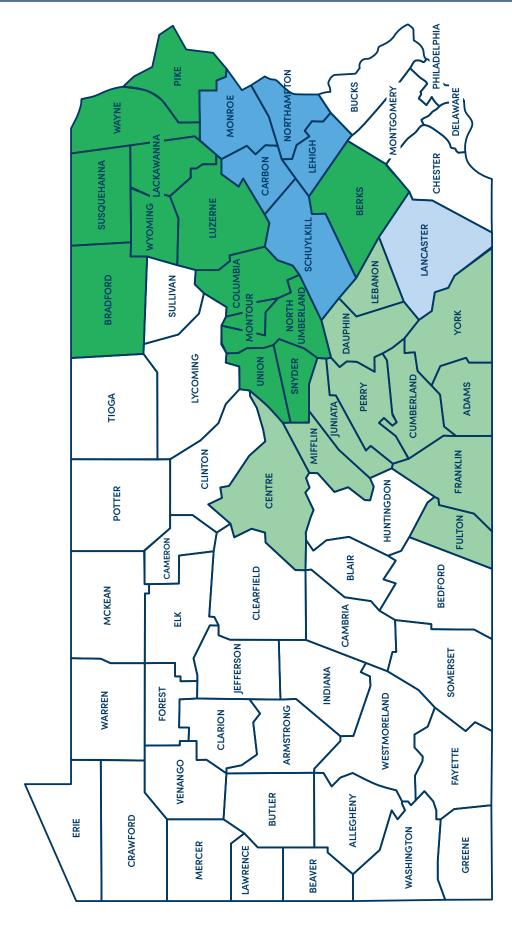
Community Blue Medicare PPO Signature Lehigh Valley

Community Blue Medicare PPO Signature Harrisburg

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

Monthly Plan Premium	Lehigh Valley/Harrisburg/Northeast: \$0	Lancaster: \$0
Part B Premium Giveback	Lengh Valley/Harisburg; S13; Northeast; S10	\$31
Out-ot-Pocket Maximum DCB Office Vieit	Network: Lehigh Valley/Harrisburg: \$7,950; Northeast: \$7,550/Catastrophic: \$10,000	Network: \$7,950/Catastrophic: \$10,000
Specialist Office Visit	1 ahiah Vallav/Harrishira: \$25 Conay IN: \$25 Conay OON: Northeast: \$20 Conay IN: \$20 Conay OON	\$25 Copay IN: \$25 Copay
Lab and Diganostic Tests (Phys. Office or Freestandina Lab.)	Lenigh variety names as a coput m, sta capaty our statements statement of coput m, statement of control of control of coput of co	SES COPIGN IN, SES COPIGN CON
Lab and Diagnostic Tests (Outpatient Facility)	Lehiah Vallev/Harrisburg: \$10 Copay IN: \$35 Copay ON: Northeast: \$0 Copay IN: \$35 Copay ON	\$10 Copgy IN: \$35 Copgy OON
X-Rays	\$20 Copay IN; \$50 Copay OON	\$20 Copay IN; \$50 Copay OON
Radiation Therapy	\$60 Copay IN; \$90 Copay OON	
Advanced I maging	Lehigh Valley/Harrisburg: \$195 Copay IN; \$325 Copay OON; Northeast: \$175 Copay IN; \$325 Copay OON	\$195 Copay IN; \$325 Copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	Length Valley/Harrisburg; \$35 Capay IN; \$60 Capay OON; Northeast; \$25 Capay IN; \$50 Capay OON	\$30 Copay IN; \$60 Copay OON
Medicare Covered Acupuncture	Lenign valley, Harrisourg; 3-35 Copady Int, Sed Copady, Northeast; 3-25 Copady Int, 3-30 Copady Con	\$30 Copay IN: \$60 Copay OON
Outputient Mental Health	SAD Copus IN: SED Copus IN: SED Copus IN: SED Copus OON	sac copay III, see copay Con
Outpatient Substance Abuse	445 Condy 11, S60 Condy OON	
Outpatient Suraical	ASC: Lehiah Vallev/Harrisbura: \$275 Copav IN: \$400 Copav OON: Northeast: \$225 Copav IN: \$400 Copav OON	ASC: \$275 Copay IN: \$400 Copay OON
		Facility: \$350 Copav IN: \$400 Copav OON
bulance		Surgice OON
Transportation	SO Copoy IN: 30% Cainsurance OON. Covered only if frin is part of continued acute care after discharace from ER.	the care after discharge from ER.
Emergency Room	\$100 Copay	
Urgent Care	\$30 Copay	\$20 Copay
Inpatient Hospital Stay	Lehigh Valley/Harrisburg: \$325/admit IN; \$225/day (days 1–7), \$0/day (days 8–90) OON;	\$325/admit IN; \$275/day (days 1–5), \$0/day (days 6–90) OON
(COVID-19 cost share Walver has been removed)	NOTINEGSI: 3,230/ damil III/, 3,225/day (days I - /), 50/ day (days 0 - 50) OON	\$425 /day (days 1-3) \$0/day (days 4-90) IN: \$500/day (days 1
	\$425/day (days 1–3), \$0/day (days 4–90) IN; \$500/day (days 1–3), \$0/day (days 4–90) OON	\$0.425.449 (44.75 + 5.5) 50.449 (44.75 + 5.5) 113, 5550, 44.7 (44.75 + 5.5) (4.75 + 5.5) (4.75 + 5.5)
Skilled Nursing Facility	\$0/day (days 1–20); \$203/day (days 21–100) IN; 30% Coinsurance OON	rance OON
Home Health	\$0 Copay IN; 30% Coinsurance OON	
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are consequently and DME Supplier.	Scan, all other brands are covered through a DME Supplier;
	continuous glucose monitrors, sensors and transmitters atspensed via retain or mail ander pratrandcy are ilmin covered diabetic supplies, IN: 30% Coinsurrance OON	mired to Abbort and Dexcom, 20% coinsurance for all other DN
Durable Medical Equipment	20% Coinsurance NON	
-	\$105 Allowance Once Per Quarter IN/OON	
OnpuO	\$0 Onduo Virtual Diabetes Program	
Spring Health	\$0 behavioral health care program	
CHF and COPD Management powered by Vida	\$0 program for COPB and congestive heart failure to manage condition through an app.	ition through an app.
Additional Telehealth Services	Services received in the control in the form of its defer out of the control in t	patient
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 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; 30% Coinsurance OON	Isulin IN; 30% Coinsurance OON
Medicare Covered Vision (Office Visit)	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 Copay IN; \$25 Copay OON
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copay OON (one every year)	
Routine Vision (Eyewear)	Standard eyeglass lenses and trames or contact lenses are covered in full. IN/ONIX 18 (200 benefit maximum applies to non-standard frames and a \$100 benefit maximum for repectality	is to non-standard trames and a \$100 benefit maximum tor spec eventer
Medicare Covered Hearing Exam	Lehigh Vallev/Harrisburg: \$25 Copay IN: \$25 Copay OON: Northeast: \$20 Copay OON	\$25 Copay IN: \$25 Copay OON
Routine Hearing Exam	Lehigh Valley/Harrisburg; \$25 Copay N; \$25 Copay OON (one every year);	
,	Northeast: \$20 Copay IN; \$20 Copay OON (one every year)	\$25 Copay IN; \$25 Copay OUN (one every year)
Routine Hearing (Hearing Aids)		n – \$999 copay IN; \$500 allowance OON
Routine Dental	Office Visit: 50 Copay IN, 30% Coinsurance OON (one every six months) Includes exam, cleaning, and fluoride treatment. X-ray: 50 Copay IN, 30% Coinsurance OON (one every year)	tment. X-ray: \$0 Copay IN; 30% Coinsurance OON (one every yed
	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 Copay IN; \$25 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum diowance of \$2,500 Combined maximum diowance diow	N
Comprehensive Denial - Supplemental	restorative Services, Endodamics, Prosmodamics, Orier Orier Virtual Managard a suggest actions benefit limits. 50% Coinsurance OON, See EOC for benefit limits.	ine services, Diagnosiics, Periodoniics: 20% Coinsardnee IN. S.
Medicare Covered Chiropractic	Lehigh Valley/Harrisburg: \$15 Copay IN; \$25 OON; Northeast: \$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$25 OON
Routine Chiropractic	Lehigh Valley/Harrisburg: \$15 Copay IN; \$25 OON (four visits); Northeast: \$15 Copay IN; \$35 Copay OON (four visits)	\$15 Copay IN; \$25 OON (four visits)
Medicare Covered Podiatry	Lehigh Valley/Harrisburg: \$25 Copay IN; \$25 Copay OON; Northeast: \$20 Copay IN; \$20 Copay OON	\$25 IN; \$25 OON
Routine Podiatry	Lehigh Valley/Harrisburg; \$25 Copay IN; \$25 Copay OON (four visits); Northeast: \$20 Copay IN: \$20 Copay OON (four visits)	\$25 Cop ay IN; \$25 OON (four visits)
Cardiac and Pulmonary Rehab and SET. Partial Hospital. Outpatient Blood	SO Consultation of the Con	
	Part D Drugs	
Formulary	Lean (Performance)	
Initial Coverage Period Limit: \$5,030. 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	Preferred Retail: Tier 1: \$6, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Date: Tier 1: \$7 Tier 9: \$47 Tier 4: \$100, Tier 5: 33%), Tier 5: 33% Tier 5: 33%
and 14 at 3x copay, except Specialty 11er 5. Mail Order: Cost sharp and 12 and up to an order of the control of	Preferred Mail Order: Tierr: 50, Tier 2: 5120, Tier 4: 5275, Tier 5 (31-day supply): 33%	(31-day supply): 33%
-day supply for 13 and 14, except operanty liet (up to 51 adys supply) verage Gap (Cost sharing is for up to 100-day supply for T1 and T2	Stational Mail Class. 1181 1. 54.5, 1181 5. 54.5, 1181 4. 50.00, 118	al o (ol-day supply). oo%
and up To a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply))	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	70% discount)
Catastrophic OOP Threshold: \$8,000	The plan pays the full cost for covered Part D drugs.	gs.

Community Blue Medicare PPO Distinct — CPA/NEPA



Community Blue Medicare PPO Distinct Northeast

Community Blue Medicare PPO Distinct Lehigh Valley

Community Blue Medicare PPO Distinct Harrisburg

Community

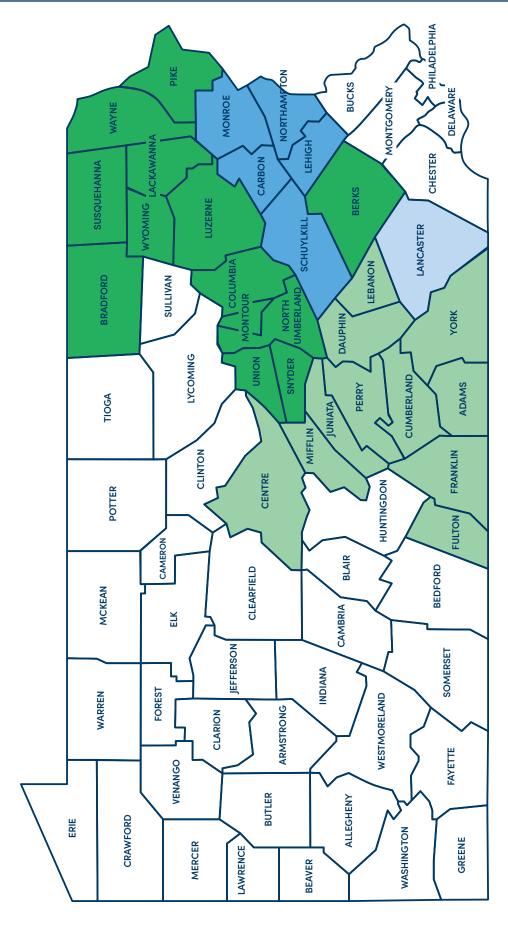
Community Blue Medicare PPO Distinct Lancaster

*Pricing is subject to CMS approval

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

Monthly Plan Premium Out-of-Pocket Maximum	Lehigh Valley/ Harrisburg/ Normeast: 52/ Network: \$5,500; Catastrophic: \$8,950	Network: \$5,500; Catastrophic: \$8,950
PCP Office Visit		SO Copay IN: SO Copay OON
Specialist Office Visit	\$15 Copav IN: \$15 Copav OON	\$5 Copav IN: \$5 Copav OON
Lab and Diagnostic Tests (Phys. Office or Freestandina Lab)		SO Copay IN: SO Copay OON
Lab and Diganostic Tests (Outbatient Facility)	SO Copaci III	SO Cond. N. So Cond. ON
X-Roxs	S20 Copay IN: \$20 Copay OON	S15 Copay IN: \$15 Copay OON
Padiation Therapy		SEO CONTROL IN SEO CONTROL ON
Advanced Imagina	(1) (2) (2) (3) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	VOC COPICITY, VOC COPICITY OF VOC
Decoration / Companies	(iii (badaa a iii)	Coursed in End (CAS) with the contract and the CAS (CAS) IN CONT
Contract of the contract of th	ISIN POLICE DE PAGO	Copay may apply my con
ulpailent rhysical and speech i nerapy	N, Nationale	Secondary III, see Copary CON
Medicare Covered Acupuncture	S15 Copay IN;	S15 Copay IN; S15 Copay OON
Outpatient Occupational Therapy	\$30 Copay IN;	\$30 Copay IN; \$30 Copay OON
Outpatient Mental Health	\$30 Copay IN;	\$30 Copay IN; \$30 Copay OON
Outpatient Substance Abuse	\$45 Copay IN:	\$45 Copay IN; \$50 Copay OON
Outpatient Suraical	ASC; \$175 Copay IN; \$175 Copay OON; F	ASC: 8175 Copay IN: 8175 Copay OON: Facility: 8245 Copay IN: \$245 Copay OON
Ambilance	Fmergent/Non-Emergent: \$250 IN.N	Non-Emergent: 30% Coinsurance OON
	COLORS IN SOUNT IN SO	CO Caraci, IN. 20% Cairac granter Control Caracing and carls of franking and cards of caracing and caracing from ED
Iransportation	SU Copay IN; 30% Coinsurance CON. Covered only ITTIF	o is part of confinued acute care after alscharge from EK.
mergency Room		S100 Copay
Urgent Care	\$30 Copay	\$10 Copay
Inpatient Hospital Stay	\$200/admit IN:	\$200/admit IN: \$200/admit OON
UVID-19 cost share waiver has been removed)		
Inpatient Psychiatry Stay	\$425/day (days 1–3), \$0/day (days 4–90) IN;	8425/day (days 1–3), \$0/day (days 4–90) IN, 8425/day (days 1–3), \$0/day (days 4–90) OON
Skilled Nursing Facility	\$0/day (days1–20); \$203/day (day	rs 21–100) IN; 30% Coinsurance OON
Home Health	\$0 Copay IN; 30%	\$0 Copay IN; 30% Coinsurance OON
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy lin continuous glucose monitors, sensors and transmitters dispensed via retail or ma	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other
	covered diabetic supplies	. IN; 30% Coinsurance OON
Durable Medical Equipment		20% Coinsurance IN, 30% Coinsurance OON
U	\$190 Allowance Once Per Quarter IN/OON	\$215 Allowance Once Per Quarter IN/OON
Onduo	\$0 Onduo Virtual	\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral he	\$0 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart	\$0 program for COPD and congestive heart failure to manage condition through an app.
Healthcare Kits	NotO	Not Covered
Fitness Benefit	Covered in Full IN; 50% Coinsurance a	Covered in Full IN, 50% Coinsurance after satisfying a \$500 Deductible OON
Additional Telehealth Services	Services covered with applica	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% C	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	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN, 30% Coinsurance OON
Medicare Covered Vision (Office Visit)	\$15 Copay IN; \$15 Copay OON	\$5 Copay IN; \$5 Copay OON
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copa	\$0 Copay IN; \$50 Copay OON (one every year)
Routine Vision (Eyewear)	Standard eyeglass lenses and frames or contact lenses are covered in ful	Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON/A S150 Benefit maximum applies to non-standard frames and a
	Sign benefit maximum for specially confact tenses	s, szud beneili maximum lor posi calaraci eyewear.
Medicare Covered Hearing Exam	Sts Copay In; Sts Copay CON	\$5 Copay IN; \$5 Copay OUN
Kourine redring Exam	sis Capay III; sis Capay OON (one every year)	T : : : : : : : : : : : : : : : : : : :
Routine Hearing (Hearing Aids) Routine Dental	Two hearing aids every year; TruHearing Advanced — \$699 cop Office Visit: \$0 Conav (one every six months) It	Iwo hearing aids every year; I'uthearing Advanced — 5899 capoy! I'uthearing Penetime — 5999 capoy II, \$500 allowance OON Office Visit: 50 Canav (one every six months) Includes exem - dennian and filiotride treatment
	Cince visit; od copal (dire ever) sixtinonins)	X-ray: \$0 Copay (one every year)
Medicare Covered Comprehensive Dental	\$15 Copay IN: \$15 Copay OON	\$5 Copay IN; \$5 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum	Combined maximum allowance of \$3,000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surger	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillocial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 10% Coinsurance IN.
Medicare Covered Chiropractic	\$20 Copay IN: \$15 OON	\$15 Copgy IN: \$15 OON
Routine Chiropractic	\$20 Copay IN: \$15 OON (four visits)	\$15 Copay IN: \$15 OON (four visits)
Medicare Covered Podiatry	\$15 IN: \$15 OON	\$51N:\$5 OON
Politine Podiatry	\$15 Copdy IN: \$15 OON (four visits)	SE Copov IN: SE OON (four visite)
Cardiac and Dulmonary Dahah and SET Dartial Hospital Outpatient Blood		CO Concer IN: 30% Coincernance OOM
מומל מוומן אי הפוומם מוומ סבו, רמ וומוויס אומן כמו המוומים מוומים מוומים מוומים מוומים מוומים מוומים מוומים מו		
	Part D Drugs	
Formulary	Lean (Per	Lean (Performance)
Network	PA MPVN 25K C	PA MPVN 25k CVS w/BPM Wrap
Deductible		20
Initial Coverage Period Limit; \$5,J30, Ketali: 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 14 at 3x copacy, except Speciality Tier 5.	Preferred Retail: Tier1: S0, Tier 2: S1 Standard Retail: Tier1: S7, Tier 2: S1	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
ail Order. Cost sharing is for up to 100-day supply for T1 and T2 and up to a -day supply for T3 and T4. except Specialty tier (up to 31 days supply)	Preferred Mail Order: Tier 1: S0, Tier 2: S0, Tier 2: S0, Tier 2: S1, Tier 2: S1, Tier 2: S21, T	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%
Coverage Gap (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	Generics (25% coinsurance) Brand (25	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
(up to 31-days supply))	The state of the s	A for a constant D along the constant of the c
Catastrophic OUP Inreshold: \$8,000	Ine plan pays the full cos	Ine plan pays the tull cost for covered Part D arugs.

New! Community Blue Medicare PPO Premier — CPA/NEPA



Community Blue Medicare PPO Premier Northeast

Community Blue Medicare PPO Premier Lancaster

*Pricing is subject to CMS approval

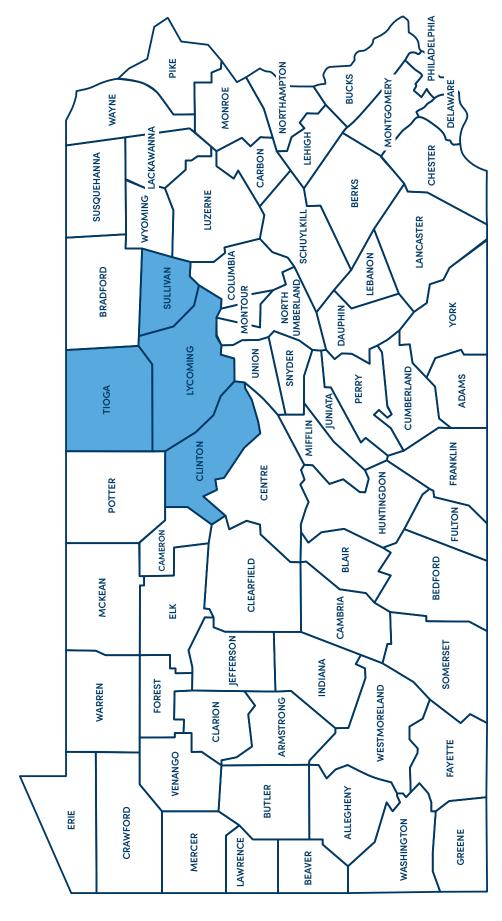
Community Blue Medicare PPO Premier Lehigh Valley

Community Blue Medicare PPO Premier Harrisburg

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

Monthly Plan Premium	846
Part B Premium Giveback	0\$
Out-of-Pocket Maximum	Newton; 54,900
DCD Office Visit	Catastrophic: 85, 950
PCF Office Visit	CONTRACTOR OF CO
Specialist Orace Visit Lab and Diggnostic Tests (Phys. Office or Freestanding Lab.)	SU CORDA IN SU CORDA CON
Lab and Diagnostic Tests (Outbatient Facility)	SO Coppay IN SO Coppay
X-Ravs	\$20 Copay, IN; \$2.0 Cobay OON
Radiation Therapy	\$60 Copay IN; \$60 Copay OON
Advanced I maging	\$150 Copay IN; \$150 Copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON
Outpatient Physical and Speech I herapy	SU COPAY IN SU COPAY OUN
Medicare Covered Acupuncture	SO COPON IN SO COPON
Outpatient Occupational Inerapy	SOUCHOUNT SET COMM
Surparient Mental Realth	NOO voor INI SEO CON SON SON SON SON SON SON SON SON SON S
Outpatient Sussignice Abuse	ACC. CATE COOK IN CATE COOK
ימוף מופוון סמו פוכמו	Facility 848 Conny IN: 852 Conny ON
Ambulance	Fmercant/Non-Fmercant-\$250 NN-Non-Fmercant-\$00N
Transportation	50 Copay IN: 30% Coinsurance OON, Covered only if trip is part of continued acute care after discharae from ER.
Emergency Room	\$100 Copav
Urgent Care	\$15 Copy
Inpatient Hospital Stay	NOO imbry 100cs
(COVID-19 cost share waiver has been removed)	***************************************
Inpatient Psychiatry Stay	\$425/day (days 1–3), \$0/day (days 4–90) N; \$425/day (days 1–3), \$0/day (days 4–90) OON
Skilled Nursing Facility	\$0/day (days 1-120); \$45/day (days 21-100) IN; 30% Coinsurance OON
Home Health Diabetic Supplies and Services	\$0 Copay IN; 30% Coinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are
	covered through a DME Supplier; continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all other covered diabetic supplies. IN: 30% Coinsurance OON
Durable Medical Equipment	20% Coinsurance IN; 30% Coinsurance OON
orc	\$120 Allowance Once Per Quarter
Onduo	\$0 Onduo Virtual Diabetes Program
spring nearin	su benavioral nearm care program win alignat roots, coacning, in-person and virtual clinical support to neip members address behavioral health needs, IN
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.
Additional Talahadith Samitas	Covered in Full IN) 50% Consultance of refer softstyling a \$500 to Legucifible OON Coving Consultance of the softstyling a \$500 to Legucifible OON Coving Consultance of the softstyling a \$500 to Legucification of the softstyling a \$500 to L
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99% Coinsurance for Part B rebotable dructs and 20% Coinsurance for part B drucs IN: 30% Coinsurance OON
	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; 30% Coinsurance OON
Medicare Covered Vision (Office Visit)	\$0 Copay IN; \$0 Copay OON
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copay OON (one every year)
Routine Vision (Eyewear)	Standard eyeglass lenses and trames or contact lenses are covered in tull. IN/OON: A \$150 benefit maximum applies to non- standard frames and a \$150 benefit maximum for specialty contact lenses, \$200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	\$0 Copay IN; \$0 Copay OON
Routine Hearing Exam	\$0 Copay IN; \$0 Copay OON (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year, TruHearing Advanced – \$699 copay, TruHearing Premium – \$999 copay IV, \$500 allowance OON
Routine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (one every six months) Includes exam, cleaning, and fluoride freatment X-ray: \$0 Copay IN; 30% Coinsurance OON (one every year)
Medicare Covered Comprehensive Dental	\$0 Copay IN; \$0 Copay OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Dicanostics, Periodontics: 0% Coinsurance, 50% Coinsurance OON. See EOC for benefit limits.
Medicare Covered Chiropractic	SZO Copay IN; SZO Copay OON
Routine Chiropractic	\$20 Copay IN; \$20 Copay OON (Eight visits)
Medicare Covered Podiatry	\$0 Copay IN; \$0 Copay OON
Routine Podiatry	SQ Copay IN, SQ Coppy OON (10 visits)
Cardiac and Pulmonary Rehab and SEI, Partial Hospital, Outpatient Blood	SU Copay IN; 30% Coinsurance UON
Formulary	Race (Ventire)
Initial Coverage Period Limit: 85,030. Retail: Cost sharing is for up to 31-day supply. Cong get up to 100-040 supply for T1 and T2 and 90-day supply for T3 and T4 at 3x	Preferred Retail: Tier 1: 50, Tier 2: 50, Tier 3: 542, Tier 4: 5100, Tier 5: 33% Standard Retail: Tier 1: 57, Tier 2: 515, Tier 2: 5100, Tier 6: 533%
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 3) days supply)	Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 5 (31-day supply): 33%
Coverage Gap (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 Specially tier funds 31-days supply)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
ro-day supply for 15 and 14, except specially liet (up to 51-days supply)) ortastrophic OOP Threshold: \$8 000	The plan prove the full coet for covered Dart D during
Carasirophic OCF III esticia: 30,000 RA Benefits — T3 and T4 offered through ICP and	The plum pulys me for covered ron to drugs.
Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

Community Blue Medicare Plus PPO — NEPA



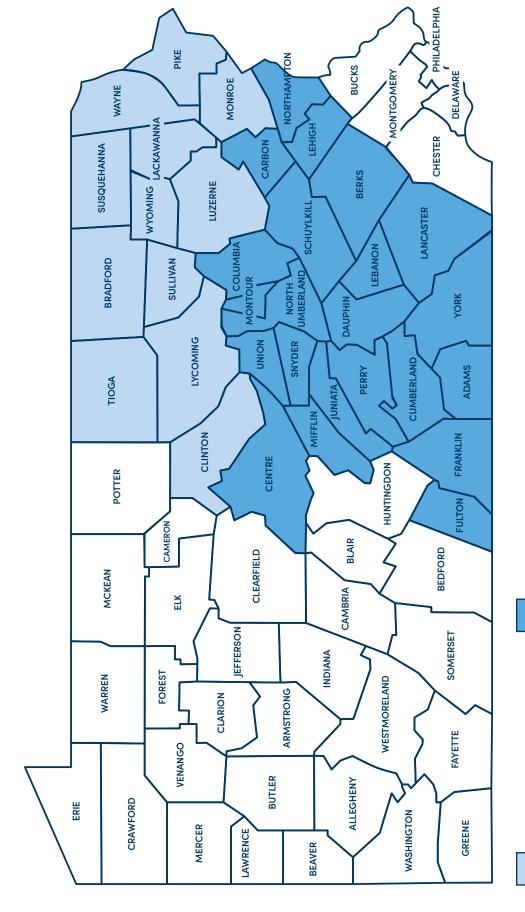
Community Blue Medicare Plus PPO

*Pricing is subject to CMS approval

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

State Copput National Control National Control National Control National Copput National Communication				
Standar Contact Indian Preferre Preferred India Preferred India Standar Standar Contact India Standar Contact India Standar Contact India Scale	Ionthly Plan Premium	0\$	\$27	\$46
Standar Standar Contaction Maxilla Preferre ept Tier 5 (3.95) and the preferred to the pref	art B Premium Giveback	\$31 Matricel, \$7,050, Catanton bin, \$10,000	\$0 Notuce 500:00 (\$0.000)	\$0 Notice of 2000: Catachia 69 050
Standar Standar Covered non-stand contact len Contact	CP Office Visit	Network, 37,330, Cards II Oprinc, 310,000	SO Copay IN: SO Copay OON	Network: 34,900, Cardshopinc: 30,930
Standar Standar Covered non-stand contact len Covered non-stand Contact len Co	pecialist Office Visit	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON
Standar Standar Contact Italy Restorative Maxillia Preferre ept Tier 5.1.544	ab and Diagnostic Tests (Phys. Office or Freestanding Lab)		\$0 Copay IN: \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
S395/adr Standar Covered non-stand contact len FrT FrT FrT FrT Tie ept FrT Tie FG/3 S2	ab and Diagnostic Tests (Outpatient Facility)		\$0 Copay IN; \$0 Copay OON	\$0 Copay IN; \$0 Copay OON
Standar Standar Covered non-stand contact len Covered non-stand Contact len Co	-Rays	\$20 Copay IN; \$50 Copay OON	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON
Standar Standar Covered non-stand contact lan Covered non-stand Contact lan Covered non-stand Contact lan Contact lan Contact lan Contact lan Contact lan Preferred Maxillia Preferred M	adiation Therapy	\$60 Copay IN; \$90 Copay OON	\$60 Copay IN; \$60 Copay OON	\$60 Copay IN; \$60 Copay OON
\$395/adr \$100% Coinsurc Standar Covered Contact len Restorativ Maxilla Di 50% Preferred Tier 50 3/4	dvanced I maging	\$195 Copay IN; \$325 Copay OON	\$175 Copay IN; \$175 Copay OON	\$150 Copay IN; \$150 Copay OON
Standar Standar Contact len Co	reventive/Screening		Covered in Full (Office visit copay may apply) IN/OON	
\$395/adr \$100/2 Standar Standar Contact lan Contact la	utpatient Physical and Speech Therapy	\$30 Copay IN; \$50 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON
Standar Standar Covered non-stand contact lan contact land contac	ledicare Covered Acupuncture	S30 Copay IN; S50 Copay OON	S15 Copay IN; S15 Copay UCN	su Copay In; su Copay UCN
S395/adi Standar Covered non-stand contact len Contact len Prin Preferred M Preferred M Tier 5.545	urparient Occupational Inerapy	Sau Copay IN; sau Copay CON	\$30 Copay IN; \$30 Copay OON	Su Copay IN; su Copay CON
\$395/adr \$100% Coinsurce \$22	urparient Mental negitn	SAE Coppay IN; SEO Coppay CON	SAE Copay IN; SEO Copay CON	64E Condition (See Copies)
\$395/adr \$39	urparient substance Abuse	ASS Capay III; assu Capay COIN	ASS. Star Star Control of the Star Control of	A SOCIATE OF THE CAPE OF THE C
Standar Coinsurc On Coinsurc On Coinsurc Standar Coordact lon Coordact lon Standar Coordact lon Standard Coordact lon Standard On Coinsurc Standard On Coinsurce of Transport of Coinsurce of Transport of Coinsurce	utpatient Surgical	ASC: \$2/5 Copay IN; \$400 Copay OON	ASC: \$1/5 Copay IN; \$1/5 Copay OON	ASC: \$175 Copay IN; \$175 Copay OON
\$395/adr \$285/adr \$200/cconsurc covered non-stand contact len contact len Maxillo DD 503/cconsurc PrT TT FTT FTT FTT FTT FTT FTT FTT FTT FT	azazinda	racinity, easter copialy in, eater copial Color	raciiii); 3243 Cobay iii, 3243 Cobay OON	Tacility: 3243 Capay III, 3243 Capay CON
\$395/adr \$100% Coinsurce \$22	ansportation	\$0 Copay IN: 30% Coir	nsurance OON. Covered only if trip is part of continued acute care aff	ter discharae from ER.
\$395/adr \$8395/adr \$8395/adr \$1000-standor \$100	mergency Room		\$100 Copay	
Standor Standor Coinsurc O% Coinsurc Standor Coordact lon contact	rgent Care	\$300	Copay	\$15 Copay
Standar Standar Covered non-stand contact len Covered non-stand contact len Co	patient Hospital Stay	O (06-9 sych) 20/02/ (3-1-3/06)		NOO timbe/00cs :NI timbe/00cs
Standar Standar Covered non-stand contact land contact land contact land haxility Restorative Maxilla Preferre ept Tire ept Tire ept Tire 50 % Tier 2: \$44	OVID-19 cost share waiver has been removed)		100 miles (2007)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
O% Coinsure Standar Covered non-stand contact len Auxilia Bis Preferre Preferre Tile FG IX Tiler 5G IX	patient Psychiatry Stay	\$425/day (days 1–3), \$0/day (days 4–90) IN; \$500/day (days 1–3), \$0/day (days 4–90), OON	\$425/day (days 1–3), \$0/day (days 4–90) IN; \$425/day (days 1–3), \$0/day (days 4–90) OON	\$425/day (days 1-3), \$0/day (days 4-90) IN; \$425/day (days 1-3), \$0/day (days 4-90) OON
Standar Standar Standar Covered non-stand contact len Maxillo D 50% E PTT Tie ept Tier Standar T	killed Nursing Facility	A (()	23 100 INI: 30% Caire result (201)	\$0/day (days 1–20); \$203/day (days 21–100) IN;
Standar covered non-stand		30/ddy (ddys 1-20), 3203/ddy (ddys 1-20), 32	s zi=ioo) iii, so% coinsarance CON	30% Coinsurance OON
Standar covered non-stand contact len cont	ome Health inhatic Sumplies and Services	\$0 Copay IN; 30%	Coinsurance OON er nharmacy limited to Abhott and HeScan all other hrands are cove	SO Copay IN; 30% Coinsurance OON
Standar Standar Covered non-stand contact len contact len Maxille Di 50% SC Contact len Preferre ept Tire ept Tire for Maxilla Preferred Maxilla Foreign Tire for Maxilla F		and transmitters dispensed via retail or mail order pha	er printingly initiated to Abbott and Dexcom, 20% coinsurance for all oth	ner covered diabetic supplies. IN; 30% Coinsurance OON
Standar Covered non-stand confact len Maxillo Maxillo Preferre ept T Tie ept Tier 5.344	urable Medical Equipment		20% Coinsurance IN; 30% Coinsurance OON	
Standar Covered non-stand contact len contact len Maxillo D 50% F T T T T T T T T T T T T T T T T T	57	\$110 Allowance Once Per Quarter IN/OON	\$195 Allowance Once Per Quarter IN/OON	\$120 Allowance Once Per Quarter IN/OON
Survices covered in full. IN/OON 4, Stot Denetif maximum of pass covered in full. IN/OON 600 for severy year. Standard eyeglass lenses and frames and a stot Denetif maximum of pass copery IN, State Capay I	onpu		\$0 Onduo Virtual Diabetes Program	
Standard eyeglass lenses and frames are covered in full IN, State Copoy IN, St	pring Health HE and CODD Management nowered by Vida	STOCK OF	su benavioral health care program	ממס מס למי
Standard eyeglass lenses and frames or contact lenses are contact lenses are for outpot lenses and size Copay IN; 525 Copay ON Too Handle en Contact lenses and size of the contact lenses	thess Benefit	SO	vered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible C	NOC
State Copay IN; \$25 Copay IN; \$25 Copay (DON) Standard eyeglass lenses and frames or contact lenses are covered infull. IN(XOI) x \$100 benefit moximum applies to non-standard frames and a \$100 benefit moximum applies to non-standard frames and a \$100 benefit moximum applies to non-standard frames and a \$100 benefit moximum for post catacract eyewear. \$25 Copay IN; \$25 Copay I	dditional Telehealth Services		Services covered with applicable Copay listed for outpatient	
Standard eveglass lenses and frames or control lenses. 250 Copay IN; 515 Copay ON (new every year) Standard eveglass lenses and frames or control lenses are covered in full. IN/OON: A 5100 benefit maximum for specially control lenses. 250 benefit minis. 250 copay IN; 515 copay ON (four visits) special lenses. 250 penses 250 copay IN; 525 copay ON (four visits) special lenses 250 copay IN; 515 copay IN; 515 copay ON (four visits) special lenses. 250 penses 250 copay IN; 515 copay I	art 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 drug	gs IN; 30% Coinsurance OON
Stondard eyegloss leaves and framamum papeis of covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and frames or contact lenses are covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specially contact lenses. \$200 benefit maximum for past addract eyewear. \$250 copay IN; \$25 copay ON (one every year)	art B Drugs — Insulin	20% Coinsurance up	to a maximum of a 535 copay for a one month supply of insulin IN; 30	U% Coinsurance OON
Standard eyeglass lenses and frames or contact lenses are covered in full. INOON 14. \$100 benefit maximum paplies to non-standard frames and of \$100 benefit maximum for specially contact lenses. \$200 benefit maximum for specially specially contact lenses. \$200 benefit maximum for specially spec	butine Vision (Office Visit)	11) 0 (2000) 11) 0 (2000) 0 (2000)	SO Copay IN: \$50 Copay OON (one every year)	NOO (page) on (page) on
contact lenses, \$200 benefit maximum for past calaract eyewear. \$25 Copay IN; \$25 Copay ON lone ever y year) \$25 Copay IN; \$25 Copay ON lone ever y year) \$25 Copay IN; \$25 Copay ON lone ever y year) \$25 Copay IN; \$25 Copay ON lone ever y year) \$25 Copay IN; \$25 Copay ON lone ever y year; Truthearing Advanced – \$589 copay; Truthearing Advanced – \$580 copay; Tr	outine Vision (Eyewear)	Standard eyeglass lenses and frames or contact lenses are	Standard eyeglass lenses and frames or contact lenses are	Standard eyeglass lenses and frames or contact lenses are
condact lesses, <u>25,00 per lam maximum no posts addict eyewedn.</u> 225 Copay IN; 325 Copay OON 226 Copay IN; 325 Copay OON 227 Copay IN; 325 Copay OON 228 Copay IN; 325 Copay OON 228 Copay IN; 325 Copay OON 229 Copay IN; 325 Copay OON 220 Copay IN; 325 Copay IN; 325 Copay OON 220 Copay IN; 325 Copay		non-standard frames and a \$100 benefit maximum for specialty	non-standard frames and a \$150 benefit maximum for specialty	non-standard frames and a \$150 benefit maximum for specialty
\$25 Copoy IN, \$25 Copoy ON (one every year)	policare Covered Hearing Evam	confact lenses, \$200 benefit maximum for post cataract eyewear.	contact lenses, \$200 benefit maximum for post cataract eyewear.	contact lenses, \$200 benefit maximum for post cataract eyewear.
Combined maximum allowance of \$2,500 Restorative Services, Endodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Endodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Endodentics, Prosthodentics, Prosthodentics, Prosthodentics, Prosthodentics, Prosthodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Endodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Endodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Prostation Services, Endodentics, Prosthodentics, Other Oral Maxillotacial Surgery, Extractions, Non-Routine Services, Consultations, Non-Routine, Services, Copacy IN; S15 Copacy ON (Gurvisits) S15 Copacy IN; S15 Copacy ON (Gurvisits) S15 Copacy IN; S15 Copacy ON (Gurvisits) S16 Copacy IN; S15 Copacy ON (Gurvisits) S17 Copacy IN; S18 Copacy ON (Gurvisits) S18 Copacy IN; S18 Copacy ON (Gurvisits) S19 Copacy IN; S18 Copacy ON (Gurvisi	putine Hearing Exam	\$25 Copay IN: \$25 Copay OON (one every year)	\$15 Copay IN; \$15 Copay OON (one eyery year)	SO Copay IN: SO Copay Oon
Office Visit: SO Copay IN; 30% Coinsurance OON (one every six months) Includes exam, cleaning, and fluoride treatment. X-ra SS Copay ON IN; 355 Copay ON IN; 255 Copay ON IN; 255 Copay ON IN; 255 Copay ON IN; 255 Copay ON IN; 255 Copay I	outine Hearing (Hearing Aids)	Two hearing aids every year;	TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 co	opay IN; \$500 allowance OON
Combined maximum allowance of \$2,500 Combined maximum allowance of \$3,000	outine Dental	Office Visit: \$0 Copay IN; 30% Coinsurance OON (one ev	rery six months) Includes exam, cleaning, and fluoride treatment. X-ra	ay: \$0 Copay IN; 30% Coinsurance OON (one every year)
Combined maximum allowance of \$2,500	ledicare Covered Comprehensive Dental	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON
Restorative Services, Facilidadomics, Other Oral/ Maxilofacial Surgary, Extractions, Non-Routine Services, Partial Services, Readountics, 10 Consurance IN. 50% Coinsurance ONI. See Cor Cor benefit limits. 515 Copay IN; 525 Copay OON (four visits) 520 Copay IN; 515 Copay OON (four visits) 520 Copay IN; 525 Copay OON (four visits) 520 Copay IN; 515 Copay OON (four visits) 520 Copay IN; 515 Copay OON (four visits) 520 Copay IN; 515 Copay OON (four visits) 520 Copay IN; 525 Copay OON (four visits) 520 Copay IN; 525 Copay OON (four visits) 520 Copay IN; 515 Copay OON (four visits) 520 Copay IN; 525 Copa	ental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2,500	Combined maximum allowance of \$3,000	Combined maximum allowance of \$3,000
Stocopoy IN; 325 Copoy ON Stocopoy IN; 325 Copoy ON (four visits)	omprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 202 Coinsurance IN.	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 102 Coinsurance IN.	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Perdodottics: 0% Coinsurance IN.
S15 Coppy IN, S25 Coppy ON (four visits) S20 Coppy IN, S15 Coppy ON (four visits)	مناهميسونايال لمسويص مسوالمو	50% Coinsurdance OON. See EOC Tor beneathimits.	50% Coinsurdance COIN. See ECC for Benefit IIMITS.	50% Coinsurance OON. See EOC Tor Benefit IImits.
S15 Copay IN; S25 Copay OON (four visits) S15 Copay IN; S15 Copay OON (four visits)	eutine Chiropractic	\$15 Copay IN; \$25 Copay OON (four visits)	\$20 Copay IN; \$15 Copay OON (four visits)	\$20 Copay IN; \$20 Copay OON (eight visits)
\$25 Copay IN; \$25 Copay ON (four visits) \$15 Copay IN; \$15 Copay ON (four visits)	ledicare Covered Podiatry	\$25 Copay IN; \$25 Copay OON	\$15 Copay IN; \$15 Copay OON	\$0 Copay IN; \$0 Copay OON
Part D Drugs Lean (Performance) Preferred Retail: Tier 1: 50, Tier 2: 55, Tier 3: 547, Tier 4: 5100, Tier 5: 33%, Standard Retail: Tier 1: 50, Tier 2: 53, Tier 2: 51, Tier 2: 53, Tier 2: 51, Tier 2: 53, Tier 2: 54, Tier 4: 5100, Tier 5: 33%, Standard Mail Order: Tier 1: 50, Tier 2: 50, Tier 3: 547, Tier 4: 5100, Tier 5: 33%, Standard Mail Order: Tier 1: 50, Tier 5: 50, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 3: 514, Tier 4: 5300, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 52, Tier 5: 545, Tier 5:	outine Podiatry	\$25 Copay IN; \$25 Copay OON (four visits)	\$15 Copay IN; \$15 Copay OON (four visits)	\$0 Copay IN; \$0 Copay OON (10 visits)
Part D Drugs Lean (Performance) Preferred Retail: Tert : 50, Tier 2: 55, Tier 2: 516, Tier 3: 547, Tier 2: 516, Tier 3: 547, Tier 2: 516, Tier 3: 547, Tier 2: 50, Tier 3: 547, Tier 2: 50, Tier 3: 547, Tier 2: 50, Tier 3: 547, Tier 5: 517, Tier 5:	ardiac and Pulmonary Rehab and SET, Partial Hospital, utpatient Blood		\$0 Copay IN; 30% Coinsurance OON	
Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100,		Par	† D Drugs	
Preferred Retail: Tier 1: 50, Tier 2: 55, Tier 3: 547, Tier 4: 5100,	ormulary	Lear	Lean (Performance)	Base (Venture)
Preferred Mail Order: Tier 1: 50, Tier 2: 51, Tier 3: 5120, Tier 4: 5275, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 521, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 521, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 521, Tier 5 (31-day supply): 33%, Standard Mail Order: Tier 1: 521, Tier 2: 545, Tier 3: 5141, Tier 4: 5300, Tier 5 (31-day supply): 33%, Generics (25% coinsurance) Brand (25% coinsurance including 70% discou	itial Coverage Period Limit: \$5,030. Retail: Cost sharing is rr 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 carifty Tier 5.		Preferred Retail: Tier 1: 80, Tier 2: 80, Tier 3: 842, Tier 4: \$100, Tier 5: 33%; Standard Retail: Tier 1: 87, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%; Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 5: 33%
Generics (25% coinsurance) Brand (25% coinsurance including 70% discou	iail Order: Cost sharing is for up to 100-day supply for and T2 and up to a 90-day supply for T3 and T4, except oecialty tier (up to 31 days supply)	Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 5 (31-day supply); 33%, Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply); 33%		Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 5 (31-day supply); 33%, Standard Mail Order: Tier 1: \$1, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply); 33%
	Coverage Gap (Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4,	195	nerics (25% coinsurance) Brand (25% coinsurance including 70% disco	func
except a pectual with cut (Up to 3 uses supply). The plannows the full creatfor covered Dort Didning. The plannows the full creatfor covered Dort Didning.	(cept specially fler (up to 31-days supply))		The plan pays the full cost for covered Part D drugs	
	A Reposite — T3 and T4 offered through ICP and		The plants and control covered and age.	-
RA Benefits — 13 and 74 offered through ICP and Tier 4 Insulins: \$35 for 31-day supply and \$105 for 90-day supply and a retail or mail order pharmacy	Reposite — T3 and T4 offered through ICP and			

Freedom Blue PPO — CPA/NEPA



*Pricing is subject to CMS approval

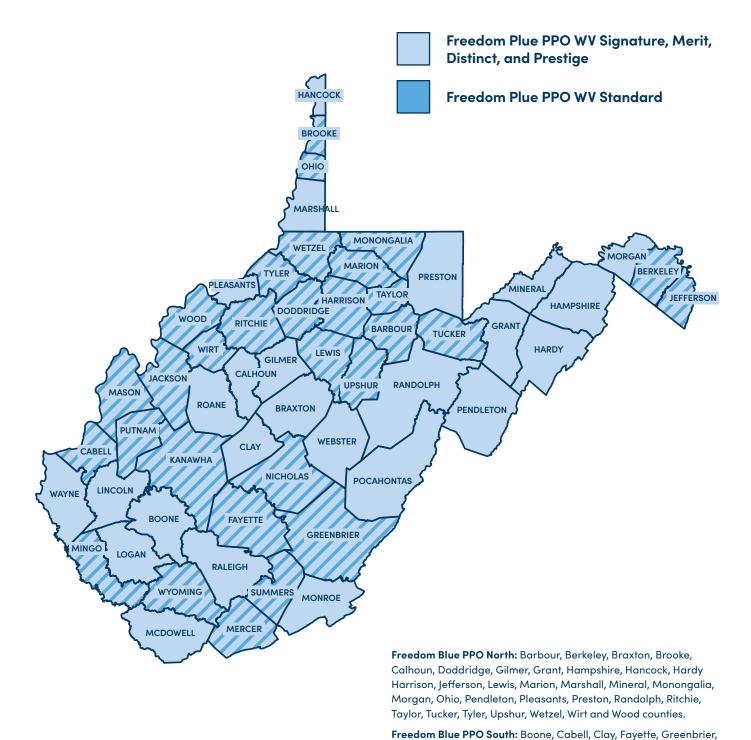
Freedom Blue PPO West Central PA

Freedom Blue PPO NEPA

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

		- VIORIDA	Signata	
Monthly Plan Premium	\$64	\$58	\$164	\$278
Part B Premium Giveback	0\$	08	0\$	0\$
Out-of-Pocket Maximum	Network: \$5,900; Catastrophic: \$8,950	Network: \$5,500; Catastrophic: \$8,950	Network: \$5,000; Catastrophic: \$8,950	Network: \$4,500; Catastrophic: \$8,950
Specialist Office Visit	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
b and Diagnostic Tests (Phys. Office or Freestanding Lab)		\$0 Copdy IN: \$20 Copdy OON	\$0 Copay IN: \$15 Copay OON	\$0 Copdy IN: \$10 Copdy OON
Lab and Diagnostic Tests (Outpatient Facility)		\$20 Copay IN; \$20 Copay OON	\$15 Copay IN; \$15 Copay OON	\$10 Copay IN; \$10 Copay OON
X-Rays	\$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	50 Copay OON	
Advanced Imaging	\$150 Copay IN; \$150 Copay OON	\$175 Copay IN; \$175 Copay OON	\$125 Copay IN; \$125 Copay OON	\$75 Copay IN; \$75 Copay OON
eventive/Screening		Covered in Full (Othce visit copay may apply) IN/OON	copay may apply) IN/OON	
Outparient Physical, Speech and Occupational Therapy, Mental Health, and Substance Abuse	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Medicare Covered Acupuncture	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON	\$35 Copay IN; \$35 Copay OON	\$30 Copay IN; \$30 Copay OON
Outpatient Surgical	ASC: \$100 Copay IN; \$100 Copay OON Facility: \$200 Copay IN; \$200 Copay OON	ASC: \$200 Copay IN; \$200 Copay OON Facility: \$225 Copay IN; \$225 Copay OON	ASC: \$150 Copay IN; \$150 Copay OON Facility: \$200 Copay IN; \$200 Copay OON	ASC: \$100 Copay IN; \$100 Copay OON Facility: \$175 Copay ION
Ambulance	Emergent/Non-Emergent: \$125 IN;	Emergent/Non-Emergent: \$275 IN;	Emergent/Non-Emergent: \$215 IN;	Emergent/Non-Emergent: \$1401N;
	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
Fransportation	SU Copay IN; 30%	50 Copay IN, 30% Coinsurance OON. Up to 24 One-way trips. Lrip limit waive	limit waived it trip is part of continued acute care atter discharge from ER.	discharge trom E.K.
Urgent Care	\$50 Copay	\$5 Copay	spay \$5 Copav	\$5 Copay
Inpatient Hospital Stay	\$340/admit1N; \$340/admit OON	\$245/day (days1-5), \$0/day (days 6-90) IN; \$245/	\$475/admit IN; \$475/admit OON	\$235/admit IN; \$235/admit OON
(COVID-19 cost share walver has been removed)		8245/day (days 1-5), \$0/day (days 6-90) OON		
	\$340/admit IN; \$340/admit OON	day (days 1-5), \$0/day (days 6-90) ΟΟΝ	\$475/admit IN; \$475/admit OON	\$235/admit IN; \$235/admit OON
Skilled Nursing Facility Home Health		\$0/day (days1–20); \$203/day (days 21–100) IN; 30% Coinsurance OON \$0 Copay IN: 30% Coinsurance OON	21–100) IN; 30% Coinsurance OON Coinsurance OON	
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies receive	Soinsurance for diabetic supplies received via retail or mail order pharmacy limited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors,	Ind LifeScan, all other brands are covered through	la DME Supplier; continuous glucose monitors,
Onduo	555 555	\$0 Onduo Virtual Diabetes Program	iabetes Program	
ing Health		\$0 behavioral health care program	Ith care program	
CHF and COPD Management powered by Vida		\$0 program for COPD and congestive heart failure to manage condition through an app.	ailure to manage condition through an app.	
Durable Medical Equipment Mary Renefit	28 Maris /14 Days	28. Maals (14 Dave IM/OO) upon discheres from en inordisat hessitied seve of SNE start to the home to qualify.	0% Coinsurance OON Iv inpatient hospital psychiatric stay, or SNE stay to	the home to a wife
Healthcare Kits			Member Selected Healthcare Kit for	Member Selected Healthcare Kit for
	Diabetes Only Healincate Kirror members with type 1 and type 2 diabetes to help manage their condition	Not Covered	members with diabetes, COPD, congestive heart failure, and/or hypertension to help manage their condition	members with diabetes, COPD, congestive heart failure, and/or hypertension to help manage their condition
Fitness Benefit		Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	ler satisfying a \$500 Deductible OON	
Part B Drugs — Chemotherapy and All Other Part B	0%-19.99	0%–19.99%Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN; 30% Coinsurance OON	insurance for all other Part B drugs IN; 30% Coinsur	rance OON
Part B Drugs — Insulin	20	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN, 30% Coinsurance OON	one month supply of insulin IN; 30% Coinsurance C	NOC
Medicare Covered Vision (Othice Visit) Routine Vision (Office Visit)	\$35 Copay IN; \$35 Copay OON	\$40 Copay IN; \$40 Copay OON \$35 Copay IN: \$50 Copay IN:	S35 Copay IN; S35 Copay OON	\$30 Copay IN; \$30 Copay OON
Routine Vision (Eyewear)	Standard eyeglass lenses and frames or conta	Standard eyeglass lenses and frames or contact lenses are covered in full, NVOON: A \$175 benefit maximum applies to non-standard frames and a \$175 benefit maximum for specialty contact lenses.	aximum applies to non-standard frames and a \$17	75 benefit maximum for specialty contact lenses.
Medicare Covered Hearing Evam	\$35 Cond 18: \$35 ON	\$200 benefit maximum for post cararact eyewear \$40 Copay IN: \$40 Copay OON	r post cataract eyewear.	NOO 2000 IN: \$30 Oos
Routine Hearing Exam	\$0 Copay IN; \$35 Copay OON (one every year)	\$0 Copay IN; \$40 Copay OON (one every year)	\$0 Copay IN; \$35 Copay OON (one every year)	\$0 Copay III; \$30 Copay OON (one every year)
rine Hedring (Hedring Alds)	Two hearing aids every year; TruHea	every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay IN; \$500 allowance OON	\$899 copay IN; \$500 allowance OON	Mo nearing alds every year, TruHearing Advanced — \$399 copay; TruHearing Premium \$699 copay IN; \$500 allowance OON
Routine Dental Medicare Covered Comprehensive Dental	S35 Copay IN: \$35 Copay OON	Office Visit: \$15 Copay IN; 30% Coinsurance OON (one every six months) X-ray: \$15 Copay IN; 30% Coinsurance OON (one every year)	1ths) X-ray: \$15 Copay IN; 30% Coinsurance OON (c	one every year)
Comprehensive Dental — Supplemental	100 (200) 000 (21) (200)	Not	Covered	too (ndo) oo (m (ndo) oo
Medicare Covered Chiropractic	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON	\$20 Copay IN; \$20 Copay OON
fine Univolved In a second Second In a second Secon	\$20 Copay IN; \$20 Copay OON (eight visits) \$35 Copay IN; \$35 Copay OON	\$20 Copay IN; \$20 Copay OON (SIX VISITS) \$40 Copay IN; \$40 Copay OON	\$20 Copay IN; \$20 Copay OON (eight visits) \$35 Copay IN; \$35 Copay OON	\$20 Copay IN; \$20 Copay OON (10 VIsits) \$30 Copay IN; \$30 Copay OON
Routine Podiatry	\$35 Copay IN; \$35 Copay OON (10 visits)	\$40 Copay IN; \$40 Copay OON (eight visits)	\$35 Copay IN; \$35 Copay OON (10 visits)	\$30 Copay IN; \$30 Copay OON (12 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood		\$0 Copay IN; 30% Coinsurance OON	oinsurance OON	
		Part D Drugs		
Formulary	NotCovered	Lean (Performance)	Base (Venture)	Base (Venture)
Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31 aday 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.	NotCovered	Preferred Standard	Preferred Retait. Tier 1: \$0, Tier 2: \$13, Tier 3: \$45, Tier 4: \$95, Tier 5: 33% Standard Retait. Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Tier 5: 33% Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31 days supply)	Not Covered	Prefered Mail Order: Standard Mail Order:	Prefered Mail Order: Tier1: \$0, Tier 2: \$27, Tier 3: \$115, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$15, Tier 2: \$57, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33%	5 (31-day supply): 33% 5 (31-day supply): 33%
Coverage Gap (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 Specially filer (up to 31-days supply))	NotCovered	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Preferred Mail: Preferred Generics: Tier 1 (\$0) Generics: Tier 1 (\$127); Standard Mail: Preferred Generics: Tier 2 (\$127); Standard Mail: Preferred Generics: Tier 3 - 5 (\$28, coinsurance) Brand (\$128, Generics) Coinsurance in Coins
Catastrophic OOP Threshold: \$8,000	NotCovered		The plan pays the full cost for covered Part D drugs.	
IDA Bonofite — T3 and T4 offered through ICB and		1		

Freedom Blue PPO — WV



^{*}Pricing is subject to CMS approval

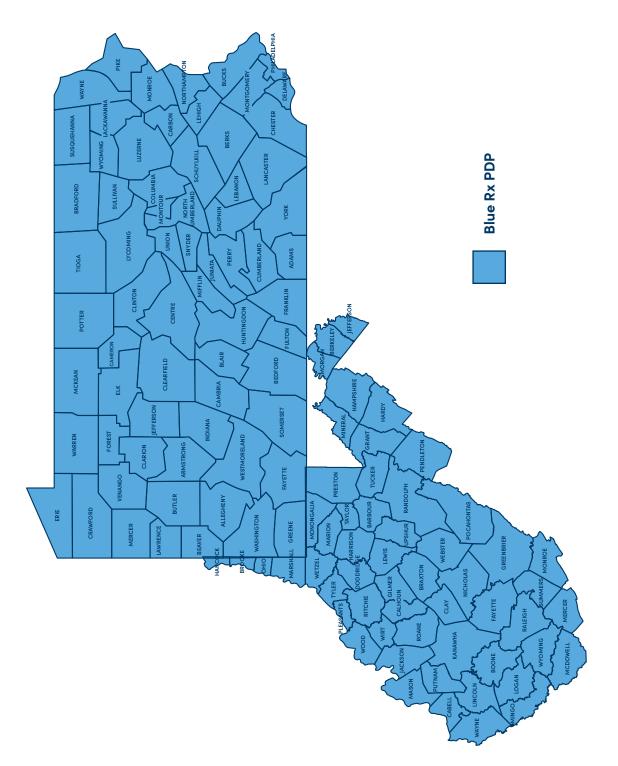
Jackson, Kanawha, Lincoln, Logan, Mason, McDowell, Mercer, Mingo, Monroe, Nicholas, Pocahontas, Putnam, Raleigh, Roane Summers,

Wayne, Webster, and Wyoming counties.

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

	Signature	Merit
Monthly Plan Premium	North: \$0/South: \$0	North: \$0/South: \$0
Part B Premium Giveback	\$10	\$85
Out-of-Pocket Maximum	Network: \$7,550; Catastrophic: \$10,000	Network: \$8,300; Catastrophic: \$13,000
PCP Office Visit		0 Copay OON
Specialist Office Visit	\$25 Copay IN; \$25 Copay OON	\$45 Copay IN; \$65 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$100 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$10 Copay IN; \$20 Copay OON	\$100 Copay IN; \$100 Copay OON
X-Rays Radiation Therapy	\$25 Copay IN; \$40 Copay OON \$60 Copay IN; \$75 Copay OON	\$75 Copay IN; \$100 Copay OON \$60 Copay IN; \$75 Copay OON
Advanced Imaging	\$250 Copay IN; \$350 Copay OON	\$300 Copay IN; \$350 Copay OON
Preventive/Screening		copay may apply) IN/OON
Outpatient Physical and Speech Therapy	\$30 Copay IN; \$50 Copay OON	\$45 Copay IN; \$55 Copay OON
Medicare Covered Acupuncture	\$30 Copay IN; \$50 Copay OON	\$45 Copay IN; \$55 Copay OON
Outpatient Occupational Therapy	\$30 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON
Outpatient Mental Health	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON
Outpatient Substance Abuse	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON
Outpatient Surgical	\$250 Copay IN; \$350 Copay OON	\$300 Copay IN; \$375 Copay OON
• 1 1	\$300 Copay IN; \$350 Copay OON	\$350 Copay IN; \$375 Copay OON
Ambulance	Emergent/Non-Emergent: \$250 IN Non-Emergent: 30% Coinsurance OON	Emergent/Non-Emergent: \$300 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		Copay
Urgent Care	\$35 Copay	\$50 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$250/day (days 1–3), \$0/day (days 4–90) IN; \$425/day (days 1–5), \$0/day (days6–90) OON	\$455/day (days 1–5), \$0/day (days 6–90) IN; \$550/day (days 1–5), \$0/day (days6–90) OON
Inpatient Psychiatry Stay	\$425/day (days 1–5), \$0/day (days 6–90) OON \$425/day (days 1–3), \$0/day (days 4–90) IN;	\$645/day (days 1–3), \$0/day (days 4–90) IN;
inpunent i sychian y dray	\$425/ddy (ddys 1–3), \$0/ddy (ddys 4–90) NN; \$500/ddy (ddys 1–3), \$0/ddy (ddys 4–90) OON	\$645/day (days 1–3), \$0/day (days 4–90) NY; \$645/day (days 1–7), \$0/day (days 8–90) OON
Skilled Nursing Facility		s 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 or covered through a DME Supplier; continuous glucose monitors, ser are limited to Abbott and Dexcom, 20% coinsurance for all	der pharmacy limited to Abbott and LifeScan, all other brands are assors and transmitters dispensed via retail or mail order pharmacy other reversed dispets; supplies NN 30°C Computation CON
Durable Medical Equipment		10% Coinsurance OON
OTC	\$85 Allowance Once Per Quarter	Not Covered
Meal Benefit	Not Covered	Not Covered
Onduo	\$0 Onduo Virtual	Diabetes Program
Spring Health		alth care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart	
Fitness Benefit		fter satisfying a \$500 Deductible OON
Additional Telehealth Services		ble Copay listed for outpatient
Part B Drugs — Chemotherapy and All Other Part B		pinsurance for all other Part B drugs IN; 30% Coinsurance OON
Part B Drugs — Insulin Medicare Covered Vision (Office Visit)	20% Coinsurance up to a maximum of a \$35 copay for a \$25 Copay IN; \$25 Copay OON	\$45 Copay IN; \$65 Copay OON
Routine Vision (Office Visit)		y OON (one every year)
Routine Vision (Eyewear)	Standard eyeglass lenses and frames or contact lenses are covered	Standard eyeglass lenses and frames or contact lenses are covered
	in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.	in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. \$200 benefit maximum for post cataract eyewear.
Medicare Covered Hearing Exam	\$25 Copay IN; \$25 Copay OON	\$45 Copay IN; \$65 Copay OON
Routine Hearing Exam	\$30 Copay IN; \$30 Copay OON (one every year)	\$40 Copay IN; \$40 Copay OON (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year; TruHearing Advanced — \$699 copay;	Two hearing aids every year; TruHearing Advanced — \$699 copay
Routine Dental	TruHearing Premium — \$999 copay IN; \$500 allowance OON Office Visit: \$0 Copay IN; 30% Coinsurance OON (one every six months) Includes exam, cleaning and flouride treatment	TruHearing Premium — \$999 copay IN; \$500 allowance OON Office Visit: \$0 Copay IN; 30% Coinsurance OON (one every six months) Includes exam, cleaning and flouride treatment
Medicare Covered Comprehensive Dental	X-ray: \$0 Copay IN; 30% Coinsurance OON (one every year) \$25 Copay IN; \$25 Copay OON	X-ray: \$0 Copay IN; 30% Coinsurance OON (one every year) \$45 Copay IN; \$65 Copay OON
Dental Allowance — Preventive and/or Comprehensive	S25 Copay IN; S25 Copay OON Combined maximum allowance of \$2,000	Combined maximum allowance of \$1,000
Comprehensive Dental - Supplemental	,	xillofacial Surgery, Extractions, Non-Routine Services, Diagnostics,
Medicare Covered Chiropractic	\$15 Copay IN; \$40 OON	\$15 Copay IN; \$40 Copay OON
Routine Chiropractic	\$15 Copay IN; \$40 OON (eight visits)	\$15 Copay IN; \$40 Copay OON (four visits)
Medicare Covered Podiatry Routine Podiatry	\$25 Copay IN; \$25 Copay OON \$25 Copay IN; \$25 Copay OON (10 visits)	\$45 Copay IN; \$65 Copay OON \$45 Copay IN; \$65 Copay OON (eight visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 Copay IN; 30% Coinsurance OON	Cardiac Rehab: \$15 Copay IN; 30% Coinsurance OON Partial Hospital: \$60 Copay IN; 30% Coinsurance OON
	2 122	Outpatient Blood: \$0 Copay IN; 30% Coinsurance OON
	Part D Drugs	
Formulary Doductible	Lean (Peri	formance)
Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31–day supply. Can get up to 100–day supply for T1 and T2 and 90–day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: \$47,	Tier 1 - Tier 2: \$0, Tier 3 - Tier 5: \$500 Preferred Retail: Tier 1: \$0, Tier 2: \$10, Tier 3: \$47, Tier 4: \$100, Tier 5: 25% Standard Retail: Tier 1: \$7, Tier 2: \$20, Tier 3: \$47,
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120,	Tier 4: \$100, Tier 5: 25% Preferred Mail Order: Tier 1: \$0, Tier 2: \$10, Tier 3: \$120,
Coverage Gap (Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4,	Tier 4: \$300, Tier 5 (31-day supply): 33% Generics (25% coinsurance) Brand (25	Tier 4: \$300, Tier 5 (31-day supply): 25% % coinsurance including 70% discount)
except Specialty tier (up to 31-days supply)) Catastrophic OOP Threshold: \$8,000	The plan pays the full cost	for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for	Tier 3 and Tier 4 Insulins: \$35 for 31-day supply and \$105 for
	90-day supply at a retail or mail order pharmacy	90-day supply at a retail or mail order pharmacy

Distinct	Prestige	Standard
North: \$35/South: \$25	North: \$39/South: \$39	\$156
\$0	\$0	\$0
Network: \$6,000; Catastrophic: \$9,550	Network: \$5,500; Catastrophic: \$8,950	Network: \$6,500; Catastrophic: \$10,000
\$20 C INL \$25 C CON	\$0 Copay IN; \$0 Copay OON	625 C INI 625 C OON
\$20 Copay IN; \$25 Copay OON \$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$20 Copay OON	\$35 Copay IN; \$35 Copay OON \$0 Copay IN; \$10 Copay OON
\$0 Copay IN; \$20 Copay OON	\$0 Copay IN; \$20 Copay OON	\$10 Copay IN; \$10 Copay OON
\$15 Copay IN; \$35 Copay OON	\$15 Copay IN; \$35 Copay OON	\$25 Copay IN; \$25 Copay OON
\$60 Copay IN; \$75 Copay OON	\$60 Copay IN; \$75 Copay OON	\$60 Copay IN; \$60 Copay OON
\$200 Copay IN; \$350 Copay OON	\$150 Copay IN; \$350 Copay OON	\$75 Copay IN; \$75 Copay OON
	Covered in Full (Office visit copay may apply) IN/OON	
\$25 Copay IN; \$30 Copay OON	\$20 Copay IN; \$30 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$30 Copay OON	\$20 Copay IN; \$30 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$30 Copay OON \$40 Copay IN; \$50 Copay OON	\$20 Copay IN; \$30 Copay OON \$40 Copay IN; \$50 Copay OON	\$35 Copay IN; \$35 Copay OON \$35 Copay IN; \$35 Copay OON
\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON	\$35 Copay IN; \$35 Copay OON
\$225 Copay IN; \$350 Copay OON	\$225 Copay IN; \$350 Copay OON	\$100 Copay IN; \$100 Copay OON
\$300 Copay IN; \$350 Copay OON	\$300 Copay IN; \$350 Copay OON	\$150 Copay IN; \$150 Copay OON
Emergent/Non-Emergent: \$250 IN	Emergent/Non-Emergent: \$250 IN	Emergent/Non-Emergent: \$225 IN
Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON	Non-Emergent: 30% Coinsurance OON
\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.	\$0 Copay IN; 30% Coinsurance OON. Covered only if trip is part of continued acute care after discharge from ER.	\$0 Copay IN; 30% Coinsurance OON. Up to 24 One-way trips. Trip limit waived if trip is part of continued acute care after discharge from ER.
	\$100 Copay	•
\$35 Copay	\$35 Copay	\$5 Copay
\$375/admit IN; \$500/admit OON	\$325/admit IN; \$500/admit OON	\$150/day (days 1–7) IN, \$0/day (days 8–90) IN; \$150/day (days 1–7), \$0/day (days 8–90) OON
\$425/day (days 1–3), \$0/day (days 4–90) IN;	\$425/day (days 1–3), \$0/day (days 4–90) IN;	\$150/day (days 1–7), \$0/day (days 8–90) OON \$150/day (days 1–7), \$0/day (days 8–90) IN;
\$500/day (days 1–3), \$0/day (days 4–90) NN,	\$500/day (days 1–3), \$0/day (days 4–90) NN,	\$150/day (days 1-7), \$0/day (days 8-90) NN, \$150/day (days 1-7), \$0/day (days 8-90) OON
	\$0/day (days 1–20); \$203/day (days 21–100) IN; 30% Coinsurance OON	
	\$0 Copay IN; 30% Coinsurance OON	
0% Coinsurance for diabetic supplies received via retail or mail sensors and transmitters dispensed via retail or mail order	order pharmacy limited to Abbott and LifeScan, all other brands are pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all	covered through a DME Supplier; continuous glucose monitors, other covered diabetic supplies. IN; 30% Coinsurance OON
	20% Coinsurance IN; 30% Coinsurance OON	
\$170 Allowance Once Per Quarter IN	\$115 Allowance Once Per Quarter IN	Not Covered
28 Meals/14 Days IN/OON upon disc	harge from an inpatient hospital stay, inpatient hospital psychiatric st	ay, or SNF stay to the home to quality
	\$0 Onduo Virtual Diabetes Program	
¢0 progra	\$0 behavioral health care program m for COPD and congestive heart failure to manage condition throug	sh an ann
	vered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible O	
	Services covered with applicable Copay listed for outpatient	ON .
0%-19.99% Coinsurance for	Part B rebatable drugs and 20% Coinsurance for all other Part B drug	s IN: 30% Coinsurance OON
	to a maximum of a \$35 copay for a one month supply of insulin IN; 30	
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
	\$0 Copay IN; \$50 Copay OON (one every year)	
Standard eyeglass lenses and frames or contact lenses are covered		
in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses.	in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses.	in full. IN/OON: A \$175 benefit maximum applies to non-standard frames and a \$175 benefit maximum for specialty contact lenses.
\$200 benefit maximum for post cataract eyewear.	\$200 benefit maximum for post cataract eyewear.	\$200 benefit maximum for post cataract eyewear.
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
\$25 Copay IN; \$25 Copay OON (one every year)	\$0 Copay IN; \$0 Copay OON (one every year)	\$0 Copay IN; \$35 Copay OON (one every year)
Two hearing aids every year; TruHearing Advanced — \$699 copay;	Two hearing aids every year; TruHearing Advanced — \$699 copay;	Two hearing aids every year; TruHearing Advanced — \$399 copay
TruHearing Premium — \$999 copay IN; \$500 allowance OON	TruHearing Premium — \$999 copay IN; \$500 allowance OON	TruHearing Premium — \$699 copay IN; \$500 allowance OON
Office Visit: \$0 Copay IN; 30% Coinsurance OON (one every six	Office Visit: \$0 Copay IN; 30% Coinsurance OON (one every six	Office Visit: \$15 Copay IN; 30% Coinsurance OON
months) Includes exam, cleaning and flouride treatment X-ray: \$0 Copay IN; 30% Coinsurance OON (one every year)	months) Includes exam, cleaning and flouride treatment X-ray: \$0 Copay IN; 30% Coinsurance OON (one every year)	(one every six months) X-ray: \$15 Copay IN; 30% Coinsurance OON (one every year)
\$20 Copay IN; \$25 Copay OON	\$0 Copay IN; \$0 Copay OON	\$35 Copay IN; \$35 Copay OON
Combined maximum allowance of \$2,500	Combined maximum allowance of \$3500	
Dostorativa Convisco End-J4: D444:		Not Covered
Restorative Services, Endodontics, Prosthodontics,	Restorative Services, Endodontics, Prosthodontics,	Not Covered
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non–Routine	
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN.	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN.	Not Covered Not Covered
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits.	Not Covered
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON	Not Covered \$15 Copay IN; \$15 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits)	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits)	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits)
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits)	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits)	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits)
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits)	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits)	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits)
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits)	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON Part D Drugs	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits)
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON Part D Drugs Lean (Performance)	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits)	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON Part D Drugs	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits)
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33%	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; \$3% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$11, Tier 3: \$45, Tier 4: \$100, Tier 5: 33%
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$30 Coinsurance OON S0 Preferred Retail: Ter 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47,	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON, \$0 Copay IN; \$	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$11, Tier 3: \$45, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47,
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; 30% Coinsurance OON Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 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%
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 CON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120,	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 5: 31% Preferred Mail Order: Tier 1: \$0, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 5: 33, Tier 3: \$105,	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$11, Tier 3: \$45, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115,
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; \$30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 5: \$1, -1 day supply): 33%	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON, \$0 Copay IN; \$	Not Covered
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 COPAY	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 5: 31% Preferred Mail Order: Tier 1: \$0, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 5: 33, Tier 3: \$105,	Not Covered \$15 Copay IN; \$15 OON \$15 Copay IN; \$15 OON (eight visits) \$35 IN; \$35 OON \$35 Copay IN; \$35 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$11, Tier 3: \$45, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$5, Tier 2: \$19, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$27, Tier 3: \$115,
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 3: \$120, Tier 4: \$103 Tier 5: \$15, Tier 5: \$1	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 3: \$7, Tier 4: \$103, Tier 5: 313% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: \$31-day supply): 33%	S15 Copay IN; \$15 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON \$15 Copay IN; \$35 COPAY (Street Visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 COPAY OON \$20 Copay IN; \$25 COPAY OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; 30% Coinsurance OON \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$257, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5 (31-day supply): 33%	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$275, Tier 6: (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141,	S15 Copay IN; S15 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; \$30% Coinsurance OON S0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42,	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier1: \$0, Tier2: \$0, Tier3: \$42, Tier4: \$100, Tier5: 33% Standard Retail: Tier1: \$7, Tier2: \$15, Tier3: \$47, Tier4: \$100, Tier5: 33% Preferred Mail Order: Tier1: \$0, Tier2: \$0, Tier3: \$105, Tier4: \$105, Tier5: 33% Standard Mail Order: Tier1: \$1, Tier2: \$45, Tier3: \$141, Tier4: \$300, Tier5: (31-day supply): 33% Pereics (25% coinsurance) Brand (25% coinsurance including 70% discound the plan pays the full cost for covered Part D drugs.	S15 Copay IN; S15 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% \$1 Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$275, Tier 6: (31-day supply): 33% \$1 Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: (31-day supply): 33% Ge	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$411, Tier 4: \$300, Tier 5 (31-day supply): 33% Preferred Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$411, Tier 4: \$300, Tier 5 (31-day supply): 33% Prefers Synon Tier Tier Synon Tier	Si5 Copay IN; Si5 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON \$15 Copay IN; \$30 OON \$15 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 OON (10 visits) \$0 Copay IN; \$30% Coinsurance OON S0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$120, Tier 4: \$100, Tier 5: 31% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: \$35 for 31-day supply): 33% Ge	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$257, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: (31-day supply): 33% nerics (25% coinsurance) Brand (25% coinsurance including 70% discound The plan pays the full cost for covered Part D drugs. Tier 3 Insulin: \$20 for 31-day supply and \$60 for 90-day supply a retail or mail order pharmacy	S15 Copay IN; S15 OON
Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 10% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$15 Copay IN; \$30 OON (eight visits) \$20 Copay IN; \$25 Copay OON \$20 Copay IN; \$25 Copay	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 0% Coinsurance IN. 50% Coinsurance OON. See EOC for benefit limits. \$20 Copay IN; \$30 OON \$20 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$30 OON (eight visits) \$0 Copay IN; \$0 Copay OON \$0 Copay IN; \$0 Copay OON (10 visits) \$0 Copay IN; \$0 Copay OON (10 visits) Part D Drugs Lean (Performance) \$0 Preferred Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$42, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail Order: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$275, Tier 5 (31-day supply): 33% Standard Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$411, Tier 4: \$300, Tier 5 (31-day supply): 33% Preferred Mail Order: Tier 1: \$21, Tier 2: \$45, Tier 3: \$411, Tier 4: \$300, Tier 5 (31-day supply): 33% Prefers Synon Tier Tier Synon Tier	S15 Copay IN; \$15 OON



*Pricing is subject to CMS approval

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

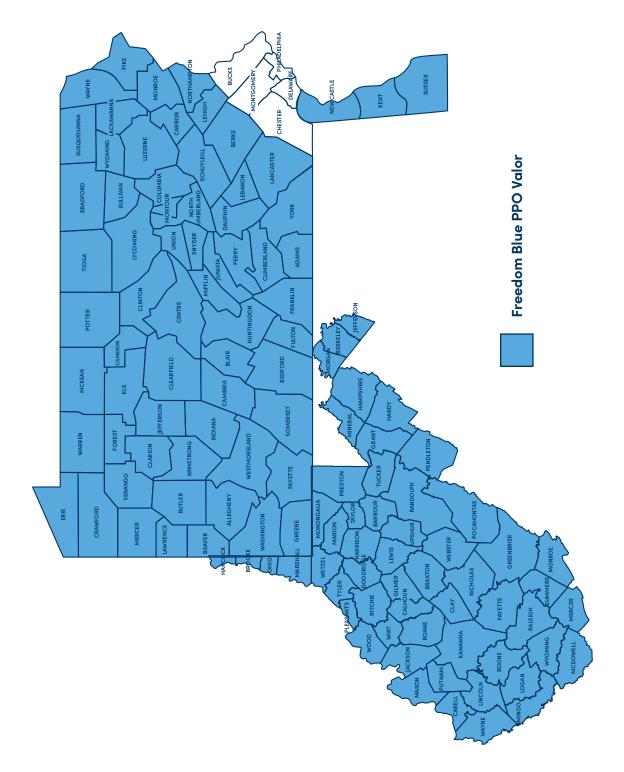
	Plus	Complete
Monthly Plan Premium	\$108.80	\$195.10
Deductible	\$545	0\$
Formulary	Base (Venture)	Base (Venture)
Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to	Preferred Retail: \$0 Preferred Generic, \$7 Generic, 20% Preferred Brand,	Preferred Retail: \$0 Preferred Generic , \$5 Generic, \$40 Preferred Brand,
31-day supply. Can get up to 100-day supply for T1 and T2 and 90-	40% Nonpreferred Drug, 25% Specialty	35% Nonpreferred Drug, 33% Specialty
day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Standard Retail: \$5 Preferred Generic, \$12 Generic, 25% Preferred Brand, 50% Nonpreferred Drug, 25% Specialty	Standard Retail: \$4 Preferred Generic, \$10 Generic, \$45 Preferred Brand, 50% Nonpreferred Drug, 33% Specialty
Mail Order: Cost sharing is for up to 100-day supply for Trand T2 and up to 90-day supply for T3 and T4, except Pecialty fier (up to 31-days supply)	Preferred Mail: Tier 1: \$0, Tier 2: \$17.50, Tier 3: 20%, Tier 4: 40%, Tier 5: 25% Standard Mail: Tier 1: \$10, Tier 2: \$30, Tier 3: 25%, Tier 4: 50%, Tier 5: 25%	Preferred Mail: Tier 1: 80, Tier 2: 912.50, Tier 3: \$100, Tier 4: 35%, Tier 5: 33% Standard Mail: Tier 1: \$10, Tier 2: \$25, Tier 3: \$112.50, Tier 4: 50%, Tier 5: 33%
Coverage Gap (Cost sharing is for up to 100-day supply for		Preferred Mail: Preferred Generics: Tier 1 (10%) Generics: Tier 2 (10%),
T1 and T2 and up to a 90-day supply for T3 and T4,	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Standard Mail: Preferred Generics: Tier1 (15%) Generics: Tier 2 (15%),
except Specialty tier (up to 31-days supply))		Generics Tiers 3–5 (25% coinsurance) Brand (25% coinsurance including 70% discount)
Catastrophic OOP Threshold: \$8,000	The plan pays the full cost	The plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day sup	Tier 3 and Tier 4 Insulins (excludes deductible); \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

Freedom Blue PPO DE Distinct, Signature, and Prestige

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

Monthly Plan Premium			
(0\$	\$25	\$39
Part B Premium Giveback		0\$	0\$
Out-of-Pocket Maximum	Network: \$6,700; Catastrophic: \$10,000	Network: \$6,000; Catastrophic: \$9,550	Network: \$5,500; Catastrophic: \$8,950
PCP Office Visit	MOO	SU Copay IN; SU Copay CON	MCC
Specialist Office Visit	\$30 Copay IN; \$30 Copay OON	\$20 Copay IN; \$20 Copay OON	\$0 Copay IN; \$0 Copay OON
and Diagnostic Tests (Phys. Office of Preestanding Lab)	Sto Copay III, see Copay Colv	Sto Copady III, Seo Copady Colin	SOCiation State Copay CON
Lab and Diagnostic Tests (Outpatient Facility)	See Copay IN; See Copay CON	SIG Copay IN; SEU Copay CON	SU Copay IN; S40 Copay CON
Dodiction Therapy	ACO Capao Coo Capao Casa	SEO Copay IN: S75 Copay OON	NOO (pdo) otto (m kado) oto
Advanced Imagina	\$225 Condy IN: \$350 Condy OON	S195 Copay IN: \$300 Copay OON	\$150 Copay IN: \$300 Copay OON
Preventive/Screening		Covered in Full (Office visit copay may apply) IN/OON	
Outpatient Physical and Speech Therapy	\$25 Copdy IN: \$50 Copdy OON		\$0 Copgy IN: \$40 Copgy OON
dicare Covered Acupuncture	\$25 Copay IN; \$50 Copay OON	\$20 Copay IN; \$50 Copay OON	\$0 Copay IN; \$40 Copay OON
Outpatient Occupational Therapy	\$30 Copay IN; \$50 Copay OON	\$20 Copay IN; \$50 Copay OON	\$30 Copay IN; \$40 Copay OON
rpatient Mental Health	\$40 Copay IN; \$50 Copay OON	\$30 Copay IN; \$45 Copay OON	\$30 Copay IN; \$40 Copay OON
tpatient Substance Abuse	\$40 Copay IN; \$50 Copay OON	\$40 Copay IN; \$50 Copay OON	\$30 Copay IN; \$40 Copay OON
Outpatient Surgical	\$225 Copay IN; \$350 Copay OON	\$195 Copay IN; \$300 Copay OON	\$155 Copay IN; \$300 Copay OON
	Copay IN; \$350 Copay OON	\$250 Copay IN; \$300 Copay OON	
Ambulance		Emergent/Non-Emergent: \$250 IN; Non-Emergent: 30% Coinsurance OON	
Transportation		Not Covered	
Emergency Room		\$100 Copay	
Urgent Care	\$40 Copay	\$35 Copay	\$0 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$175/day (days 1–5), \$0/day (days 6–90) IN; \$350/day (days 1–5), \$0/day (days 6–90) OON	\$350/admit IN; \$350/day (days1-5), \$0/day (days 6-90) OON	\$295/admit IN; \$395/admit OON
Inpatient Psychiatry Stay		\$425/day (days1-3), \$0/day (days 4-90) IN:	\$425/day (days 1-3), \$0/day (days 4-90) IN;
	ays1-3), \$0/day (days 4-90) OON	\$500/day (days1-3), \$0/day (days 4-90) OON	
Skilled Nursing Facility Home Health		eo/day (days 1-zu); szus/day (days z1-100) IN; su% Coinsurance Od SO Copay IN: 30% Coinsurance OON	NO
Diabetic Supplies and Services	0% Coinsurance for diabetic supplies received via retail or mail or	0% Coinsurance for diabetic supplies received via retail or mail order pharmacy innited to Abbott and LifeScan, all other brands are covered through a DME Supplier; continuous glucose monitors, conserved via retail or wail order pharmacy and innited to Abbott and Davors on the property of the pharmacy and transfer and included in 18.30% Chinesurance OOM	rre covered through a DME Supplier; continuous glucose moni
Durable Medical Fauinment	sensors and fransmirers dispensed vid reidii of mairorder p	20% Coinsurance IN: 30% Coinsurance ON	all other covered alabelic supplies. IIV, 50% coinsurance CON
	\$95 Allowance Once Per Quarter IN	\$120 Allowance Once Per Quarter IN	\$135 Allowance Once Per Quarter IN
Meal Benefit	Not Covered	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 qualit
Onguo Spring Health		\$0 Unduo Virtual Diabetes Program	
CHF and COPD Management powered by Vida	\$0 progran	n for COPD and congestive heart failure to manage condition thro	ough an app.
Fitness Benefit	Cov	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON	e OON
Additional Telehealth Services		Services covered with applicable Copay listed for outpatient	
Part B Drugs — Chemotherapy and All Other Part B	U%-19.99% Coinsurance for h	UX-1929% Communation for Part Bright and Grade Communation for International Bright IN-30% Communation COUNTY Communication County Coun	rugs IN; 30% Coinsurance OON
licare Covered Vision (Office Visit)	\$30 Copay IN: \$30 Copay OON	S20 Copav IN: \$20 Copav OON	SO Copay IN: SO Copay OON
fine Vision (Office Visit)		\$0 Copay IN: \$50 Copay OON (one every year)	NOO (BOO) ON (BUILDING)
Routine Vision (Eyewear)	Standard eyeglass lenses and frames or contact lense	eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for	o non-standard frames and a \$100 benefit maximum for
	eds	cialty contact lenses. \$200 benefit maximum for post cataract eye	ewear.
Medicare Covered Hearing Exam		\$20 Copay IN; \$20 Copay OON	\$0 Copay IN; \$0 Copay OON
Routine Hearing Exam	\$30 Copay IN; \$30 Copay OON (one every year)	\$30 Copay IN; \$30 Copay OON (one every year)	\$0 Copay IN; \$0 Copay OON (one every year)
Routine Dental	Office Visit: \$0 Copay IN: 30% Coinsurance OON (one eye	Office Visit: St Conov IN: 30% Change sever year, Industrial Advances — sees opportunity and flucified rendment Won earning also every year, Industrial Advances — sees opportunity and flucified rendment Won severy Many 10% Change severy severy months includes exam cleaning rendment and flucified rendment Won severy Many 10% Change severy which includes exam cleaning rendment in the severy warm.	Scopay In, 3500 allowance OON (-ray: \$0 Copay IN: 30% Coinstirance OON (one every year)
Medicare Covered Comprehensive Dental	\$30 Copay IN; \$30 Copay OON	S20 Copav IN: \$20 Copav OON	SO Copay IN: SO Copay ON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2000	Combined maximum allowance of \$2500	Combined maximum allowance of \$3500
Comprehensive Dental - Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 40% Coinsurance with a maximum	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 40% Coinsurance with a maximum	Restorative Services, Endodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 40% Coinsurance with a maximum
Medicare Covered Chiropractic	\$2000 Allowance IN/OON. See EOC for benefit limits.	_	_
Routine Chiropractic	\$15 Copav IN: \$30 OON (eight visits)	S10 Copav IN: S15 OON (eight visits)	\$0 Copay IN: \$0 OON (eight visits)
Medicare Covered Podiatry	\$30 Copay IN; \$30 Copay OON	\$20 Copay IN; \$20 Copay OON	\$0 Copay IN; \$0 Copay OON
Routine Podiatry	\$30 Copay IN; \$30 OON (10 visits)	\$20 Copay IN; \$20 OON (10 visits)	\$0 Copay IN; \$0 OON (10 visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood		\$0 Copay IN; 30% Coinsurance OON	
Earmilan	Part D Drugs	Drugs Jann (Berformance)	
Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply, Can get up to 100-day supply for If and 20-day supply for If and 30-day supply for If a control of the supply of the supply can get up to 100-day supply for If and 30-day supply for If a control of the supply can get up to 100-day supply for If a control of the supply can get up to 100-day supply for If a control of the supply can get up to 100-day supply for If a control of the supply can get up to 100-day supply can		Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	33% 33%
10 Order: Cost sharing is for up to 100–day supply for and T2 and up to a 90–day supply for T3 and T4, except		Preferred Mail: Tier1: 50, Tier 2: 50, Tier 3: \$120, Tier 4: \$275, Tier 5: 33% Standard Mail: Tier 1: \$21, Tier 2: \$45, Tier 3: \$141, Tier 4: \$300, Tier 5: 33%	33% .33%
opecially free (up to 31-argys supply for Coverage Gap (Costs tharring is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except	Gen	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	(tonnut)
Specialty tier (up to 31-days supply)) Catastrophic OOP Threshold: \$8.000		The plan pays the full cost for covered Part D drugs.	
DA B 424 T. 2 2 - 1 T4 - 444 1 D 1		100 June 100	

Freedom Blue PPO Valor — PA, WV, DE

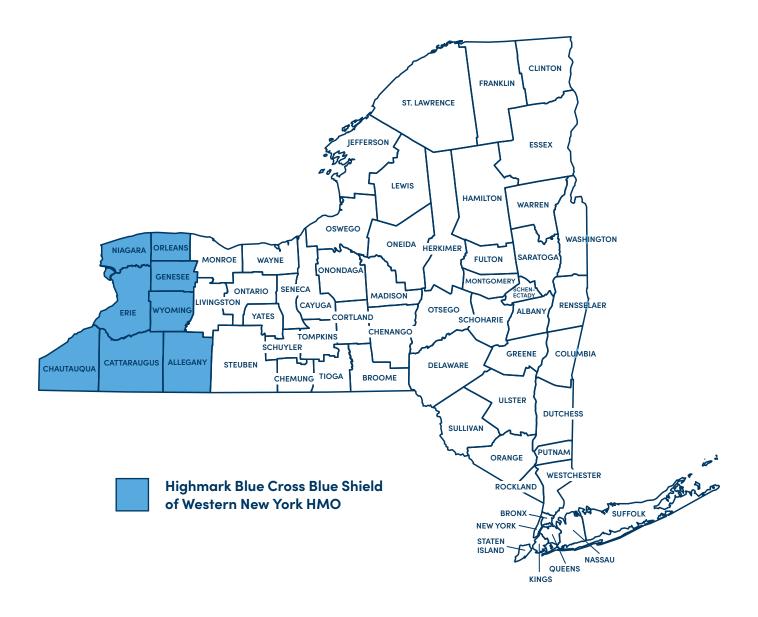


*Pricing is subject to CMS approval

Freedom Blue PPO Valor — PA, WV, DE (Products and pricing by county)

	Valor
Monthly Plan Premium	OS OS
Part B Premium Giveback	09\$
Out-of-Pocket Maximum	Network: \$6,000; Catastrophic: \$8,950
PCP Office Visit	\$0 Copay IN; \$0 Copay OON
Specialist Office Visit	\$10 Copay IN; \$10 Copay OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay IN; 835 Copay OON
Lab and Diagnostic Tests (Outpatient Facility)	\$0 Copay IN; \$35 Copay OON
X-Rays	\$20 Copay NIV; 336 Copay OON
National Instable	(CADA) (N. 22) E CADA
Preventive/Screening	Covered in Full Office visit conor may apply IN/ON
Outpatient Physical and Speech Therapy	\$15 Copay IN; 835 Copay OON
Medicare Covered Acupuncture	\$15 Copay IN; \$35 Copay OON
Outpatient Occupational Therapy	SIS Copay NN 335 Copay OON
Outpatient Mental Health	SE COPAN INV. 225 COPAN
Outparlent Substance Abuse	Sab Chapture (Comm. And Comm. And Co
Ourparient surgical	\$29.45 Comm. NN: 4375 Comm. OON
Ambiilance	Emergent/Non-Emergent 976/C Non-Emergent 976/Colineurance OON
Transportation	50 Copay IN; 30% Coinsurance OON, Up to 34 One-way trips. This limit is part of continued care are after discharae from ER. (Not Covered in DE)
Emergency Room	\$100 Copay
Urgent Care	\$50 Copay
Inpatient Hospital Stay	S275/ordmit No. S385/ordmit No. S385
(COVID-19 cost share waiver has been removed)	
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
Skilled Nursing Facility	\$0/day (days 1-20); \$203/day (days 21-100) IN; 30% Coinsurance OON
Home Health	SU CODAY IN; SU CO
Diabetic Supplies and Services	U% Consurance for alaberic supplies received via refail of mail order pharmacy limited to Abbott and LiteScan, all other brands are covered through a UNIL Supplier; continuous glucose monitiors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom, 20% coinsurance for all Ather roward Africhetic entailier IN 310% Chistorianna ONI.
Durable Medical Equipment	20% Caisurance N. Caisurance O.O.
OTC	Sign Allowance Once Per Courter IN
Onduo	\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.
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	U.*-19:39% Construction for traff is leaded to the dark of some months small but of principles and O.M. Chinatanace U.N. O.*-19:39% Construction to a movel many of a St. Commission months small but of principles and O.M. Chinatanace U.N. O.** Of Chinatanace under a movel months of the control months are not a month small but of the control months and the control months are not a month of the control months and the control months are not a months are not a months and the control months are not a month and a months are not a mon
Medicare Covered Vision (Office Visit)	S10 Copay NON
Routine Vision (Office Visit)	\$0 Copay IN; \$50 Copay OON (one every year)
Routine Vision (Eyewear)	Standard eyeglass lerses and frames or conduct lerses are covered in full. INVOXIX.45150 benefit maximum applies to non-standard frames and a
Medicare Covered Hearina Exam	SIO Copay NO.
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 OON
Routine Dental	Office Visit: \$0 Copay IN, 30% Coinsurance CON (one severy six months) Includes examp, cleaning, and fluoride treatment.
Medicare Covered Comprehensive Dental	STOCK
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$3,000 (PA, DE)/\$2,000 (WV)
Comprehensive Dental — Supplemental	PA/WV: Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Nan-Routine Services, Diagnostics, Periodontics: 20% Cofisuarene Ni 50% Confisuarene ONI. See EDC for benefit limits. DE: Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Nan-Routine Services, Diagnostics, Periodontics.
	40% Coinsurance with a maximum \$3000 Allowance IN/OON. See EOC for benefit limits.
Medicare Covered Chiropractic	Si5 Copay NN, 835 Copay OON
Routine Chiropractic	SIS COPOLINES (SECTION (SECTION)
Routine Podiatry	STO CORDANIS STO CONVICTOR
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$0 Capay IN; 30% Cainsurance ON
	Part D Drugs
Formulary	Not Covered
Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100 year upply for 11 and 12 and 90-day supply for 11 and 12 and 30-day supply for 13 and 14 at 3x coops, except 50e-day Inject 12 and 14 at 3x and 14 at 3x and 14 at 3x and 15 and	Not Covered
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 lier (up to 31—days supply)	Not Covered
Initial Coverage (Mail Order: Cost sharing is for up to 90–day supply except Specialty tier (up to 31–days supply)	Not Covered
Coverage Gap (Cost sharing is for up to 100–day supply for T1 and T2 and up to a 90–day supply for T3 and T4 expent Specialty for (in to 31–days supply)	Not Covered
Solution Supply 101 13 and 14, except specially liet (up to 31 - adys supply)) Cotastrophic OOP Threshold: \$8,000	Nat Countral
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Not Covered

Highmark Blue Cross Blue Shield of Western New York HMO



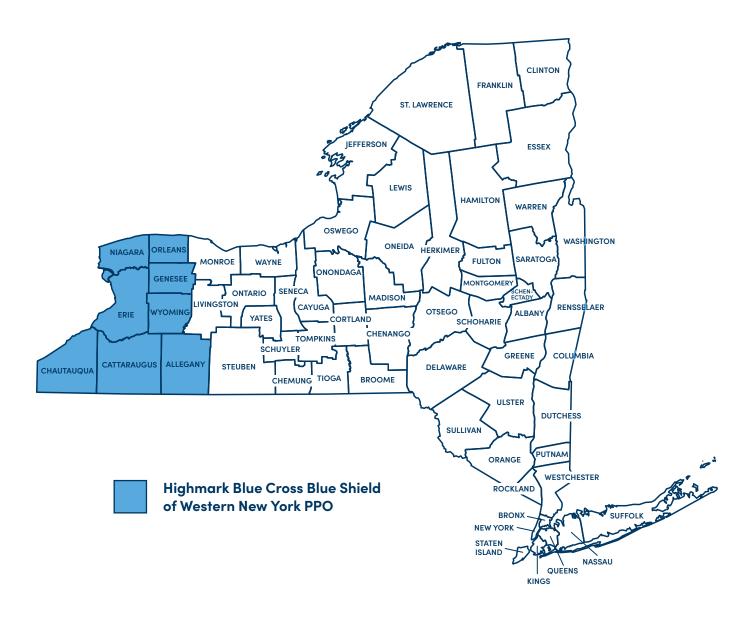
^{*}Pricing is subject to CMS approval

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

Seathly Prevalent Section (Per Prevalent Section (Per Value) Secti		21.0			
The Principal Conference of the Company of the Comp	A III DI D	BlueSaver HMO			
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Labe and Diagneseric Feets (Outpellined Facility) Add Coppary IX 540 Diagneseric test IX No. 10 Diagneseric Vision IX					
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Bedeleties Thereapy Bedeleties Thereapy BYS Coopy IN SYS Coopy IN SY					
Advanced imaging ### S125 Copys IN ### S125 Copy IN ### S125 Copys					
Precention Servening \$0 Coppy IN \$0 Coppy					
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Medicare Govered Augusechure (SS Cappy IN) (See Ca					
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Dutpoined Supplied Cincided Observation) \$297 Coppy IN \$297 Copp					
Dutpotter Suggical (Includes Observation) \$295 Coppy IN \$295 Coppy IN \$295 Coppy IN \$295 Coppy IN \$296 Cop					
Ambidunce \$395 Copey IN \$395 Copey Introversion Introversion \$395 Copey Introversion Introver					
Ambelance Temperapriation Temperapriat	Outpatient Surgical (Includes Observation)				
Transport from Special Course of Street Stre					
Emergency Reom Since Open					
Lurgent Code Second Code					
inposition in thospital Stay (CMD-19, et al. that switch has been removed) (S196 per day for days) 1–5, \$1,000.00 PM kap per year (S100 PM kap to 19, 15, 15,000 PM kap per year (S100 PM kap to 19, 15, 15,000 PM kap per year (S100 PM kap to 19, 15, 15,000 PM kap per year (S100 PM kap to 19, 15, 15,000 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 15, 100 PM kap per year (S100 PM kap to 19, 15, 15, 15, 15, 15, 15, 15, 15, 15, 15	Emergency Room				
COVID-19. Social share waiver has been removed) 9.300 per doy for days 1–5, \$1,000 U.O.P Most per year 9.300 per doy for days 1–10, \$1,000 U.O.P Most per year 9.300 per doy for days 1–10, \$2,000 per doy for days 2–100. No yearly breefill are for days 2–100 No yearly		\$55 C	орау		
inpatient Psychiatry Stey \$39 per day for days 1-4, \$1,580 DOP Max per year \$30 per day for days 1-2, \$20 per day for days 1-10, \$30 per days for days 1-10, \$30		\$360 per day for days 1–5, \$1,800 OOP Max per year	\$400 per day for days 1–5, \$2,000 OOP Max per year		
Sibiled Nursing Facility Sible for yor for days 1–20, \$203 per day for days 2–100. No yearly benefit period maximum. Moreine Realth Diabelits glucoments, lest stip, and locare brands dispensed version and locar pharmacy are limited to build-from all Society No. 200 capy No. 2					
Stores Health Society					
Diabetic Supplies and Services Diabetic Supplies and Services Continuous glucose wonshors, sensors and frantramiters dispensed via refail or mail order pharmacy are limited to LifeScan and Roche. Continuous glucose wonshors, sensors and frantramiters dispensed via refail or mail order pharmacy are limited to Abbott and Decom All of the deserted Services and frantramiters dispensed via refail or mail order pharmacy are limited to Abbott and Decom All of the deserted Services on the control of the services on the services of the services of the services on the services of the services of the services on the services on the services of					
Diabetic glucometer, test strip, and lanest brands dispensed via refail or man dired phormacy are limited to LifeScan and Roche, Continuous glucose monitors, essensor and transmitters dispensed via refail or mail order phormacy are limited to LifeScan and Roche, Continuous glucose monitors, essensor and transmitters dispensed via refail or mail order phormacy are limited to LifeScan and Roche, Continuous glucose monitors and strip and the continuous glucose monitors and the continuous glucose glucose and the continuous glucose glucos			· ·		
10TC	Subcite supplies and set vices	Diabetic glucometer, test strip, and lancet brands dispensed via Continuous glucose monitors, sensors and transmitters dispensed v	reťail or mail order pharmacy are limited to LifeScan and Roche. ria retail or mail order pharmacy are limited to Abbott and Dexcom.		
Med Benefit 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. 100% for one medi per day for seven days upon your stay. 100% for one medi per day for such as a SNF or Inpatient Psychiatry stay. 100% for one medical per day for insufficial part of the stay of the st	Durable Medical Equipment	\$0 compression stockings, diabetic	c shoes/inserts; 20% all other items		
Must be curvated within 30 days of discharge. So Ondou Virtual Diabetes Program Spring Health So Ondou Virtual Diabetes Program So Dehavioral health care program Fitness Benefit Covered in Full Services covered covered covered in Full Services covered covered covered in Full Services covered covered covered covered in Full Services covered covered covered covered in Full Services covered covered covered covered covered in Full Services covered co	OTC	\$25 quarterly allowance	Not Covered		
Spring Health So Dehavioral health care program	Meal Benefit	Must be activated with	in 30 days of discharge.		
CHF and COPD Management powered by Vida Sepress	Onduo				
Covered in Full Additional Telehealth Services Services covered with applicable Copay listed for outpatient Part B Purgs - Themotherapy and All Other Part B Purgs - Insulin 20% Coinsurance for Part B Purgs - Insulin 20% Coinsurance fo	Spring Health	\$0 behavioral hea	alth care program		
Additional Telehealth Services Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part B Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy and All Other Part Brugs IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy Allowance of Stoody IN Part B Drugs – Lehemotherapy	CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart	failure to manage condition through an app.		
Part B Drugs – Chemotherapy and All Other Part B drugs IN Part B Drugs – Insulin	Fitness Benefit	Covere	d in Full		
Part B Drugs – Insulin ### Medicare Covered Wisin (Office Visit) ### S30 (except \$50 for diobetier fertinal eye exam) ### \$30 (except \$50 for diobetier fertinal eye exam) ### \$30 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$50 for diobetic retinal eye exam) ### \$40 (except \$60 for diobetic retinal eye exam) ### \$40 (except \$60 for diobetic retinal eye exam) ### \$40 (except \$60 for diobetic retinal eye exam, leaning and exam, leaning and exam, leaning and exam	Additional Telehealth Services	Services covered with applica	ble Copay listed for outpatient		
Medicare Covered Vision (Office Visit) S25 Coppy IN S25 Coppy IN S25 Coppy IN S26 Coppy IN S26 Coppy IN S26 Coppy IN S27 Coppy IN S27 Coppy IN S27 Coppy IN S27 Coppy IN S28 Coppy IN S29	Part B Drugs — Chemotherapy and All Other Part B	0%–19.99% Coinsurance for Part B rebatable drugs	s and 20% Coinsurance for all other Part B drugs IN		
Medicare Covered Vision (Office Visit) S25 Coppy IN S25 Coppy IN S25 Coppy IN S25 Coppy IN S26 Coppy IN S26 Coppy IN S26 Coppy IN S27 Coppy IN S28 Coppy IN S29 Coppy IN S29 Coppy IN S29 Coppy IN S28 Coppy IN S28 Coppy IN S29 C	Part B Drugs — Insulin	20% Coinsurance up to a maximum of a \$3	35 copay for a one month supply of insulin		
Routine Vision (Eyewear) Routine Hearing Exam S 30 Cappy IN (see every year) Routine Hearing Exam Routine Dantal Gffices \$20 Cappy IN, (see yeary year) S 30 Cappy IN, (see yeary year) Medicare Covered Comprehensive Dental Groutine Example See See See See See See See See See S	Medicare Covered Vision (Office Visit)				
Routine Vision (Eyewear) Routine Hearing Exam S 30 Cappay IN Season Scappay IN Sea	Routine Vision (Office Visit)	\$25 Copay IN	\$25 Copay IN		
Medicare Covered Hearing Exam Sat Coppy IN Sat Coppy IN Routine Hearing (Hearing Aids) Two hearing oids every year) Not Covered Routine Dental Office: \$20 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flourid readment. P. Ray: \$30 Coppy IN, (two per year) Includes exam, cleaning and flour	Routine Vision (Eyewear)	\$100 Allowance for routine eyewear	Not Covered		
Seutine Hearing (Hearing Aids) Two hearing idds every year Tutheuring Advanced — \$699 copy; Not Covered					
Routine Hearing (Hearing Aida) Turlearing adis every year; Turlbearing Advanced — \$699 copay Turlbearing Premium — \$999 copay Office: \$0 Coppy IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; (five per year) Includes exam, cleaning and flouride treatment. X-Ray; \$0 Copay IN; \$40 Copay; IN; \$40 Copay; Extractions, Non-Routines Revices, Diagnostics, Periodontics, Coher Oral/ Maxilfocatiol Surgery, Extractions, Non-Routines Revices, Diagnostics, Periodontics; Sot Coinsurance IN; Periodontal cleanings 9% copay IN; (fixe per year) Includes exam, cleaning and flouride treatment. And surgery includes exam, cleaning and flourides and surgery includes exam, cleaning and flourides and surgery includes exam, cleaning and flourides and surgery includes exa					
Routine Dental Office: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN; (two per year) Includes exam, cleaning and flouride treatment. X-Ray: \$0 Copay IN Partial flooride treatment. X-Ray: \$0 Copay IN	Routine Hearing (Hearing Aids)				
Medicare Covered Comprehensive Dental S30 Coppy IN (one every year) S40 Coppy IN S40 Cop	Routine Dental				
Dental Allowance — Preventive and/or Comprehensive Combined maximum allowance of \$2000 Comprehensive Dental — Supplemental Restorative Services, Endodonites, Prosthodonites, 10ther Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodonites: 50% Coinsurance IN, Periodonital cleanings \$20 Coppy IN, See EOC for benefit limits. Medicare Covered Chiropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Covered Portropractic S15 Coppy IN (six per plan year) Medicare Coverage Portropractic S15 Coppy IN (six per plan year) Medicare Coverage Portropractic S15 Coppy IN (six per plan year) Medicare Coverage Portropractic S15 Coppy IN (six per plan year		flouride treatment. X-Ray: \$0 Copay IN (one every year)	flouride treatment. X-Ray: \$20 Copay IN (one every year)		
Restorative Services, Endodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 0% coinsurance IN. Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 0% coinsurance IN. Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 0% coinsurance IN. Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 0% coinsurance IN. Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 20 Coppy IN See EOC for benefit limits. Medicare Covered Podiatry Sist Coppy IN (six per plan year) Sist Coppy IN	Medicare Covered Comprehensive Dental	\$30 Copay IN	\$40 Copay IN		
Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings 0% coinsurance IN. See EOC for benefit limits. Medicare Covered Chiropractic S15 Copay IN (six per plan year) S30 Copay IN S30 Copay IN S40 Copay IN (here visits) Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Part D Drugs Fundamental Funda	Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2000	Combined maximum allowance of \$1000		
Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$20 Copay IN. Medicare Covered Chiropractic S15 Copay IN (six per plan year) S30 Copay IN (six per plan year) S40 Copay IN (six per plan	Comprehensive Dental — Supplemental				
Cleanings 9% coinsurance IN. See EOC for benefit limits. S15 Copay IN					
Medicare Covered Podiatry S30 Copay IN S40 Copay IN Cardiac Rehab: \$10 Copay IN Partial Hospital, Outpatient Bload Combined Acupuncture and Massage Therapy Allowance Part D Drugs Formulary Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN					
Routine Chiropractic \$15 Copay IN (six per plan year) \$30 Copay IN (Sox per plan year) \$30 Copay IN (Moltree visits) \$30 Copay IN (Moltree visits) \$30 Copay IN (Moltree visits) \$40	M - di C d Chi di -				
Medicare Covered Podiatry Soutine Podiatry Cardiac Rehab: \$10 Copay IN Partial Hospital, Outpatient Blood Partial Hospital, Outpatient Blood Soutine Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Outpatient Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Outpatient Blood: \$0 Copay IN Portial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Furtary In In Inter Blood: \$0 Copay In Inter Blood: \$0 Copay In Inter Blood: \$0 Fire Inter Blood: \$0					
Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital Hospital (SSE Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: SSE Copay IN Outpatient Blood: \$0 Copay IN Partial Hospital: \$0 Copay					
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Part D Drugs Formulary Deductible Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$250 Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, sexcept Specialty tier (up to 31-days supply) For T1 and T2 and up to a 90-day supply for T3 and T4, sexcept Specialty tier (up to 31-days supply) Coverage Gap (Cost sharing is for up to 100-day supply for T3 and T4, sexcept Specialty Tier (up to 31-days supply) Coverage Gap T3 and T4 of Secondary Allowance Coverage Gap Stages Cardiac Rehab: \$10 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Out					
Partial Hospital, Outpatient Blood Partial Hospital, S55 Copay IN Outpatient Blood: \$0 Copay IN Outpatient Bload: \$0 Fire 1- Supay In Fire: \$0 Tier: \$0 Tie					
Outpatient Blood: \$0 Copay IN Combined Acupuncture and Massage Therapy Allowance Part D Drugs Fundamental					
Part D Drugs Formulary Deductible Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$250 Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$350 Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, sexcept Specialty tier (up to 31-days supply) Experimental Preferred Retail: Tier 1: \$0, Tier 2: \$12, Tier 3: \$42, Tier 4: \$24, Tier 4: \$24, Tier 5: \$94, Tier 4: \$250, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: \$97, Tier 4: \$100, Tier 5: \$100, Ti	rui iiui поsрітаї, Оитратіент blood				
Formulary Fundamental Fundame	Combined Acupuncture and Massage Therapy Allowance	4050	4400		
Fundamental Fire1-Fire2: S07 Fire1-Fire5: \$47 Fire1-Fire5			,		
Deductible Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$250 Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$350 Tier 4: \$94, Tier 6: \$27% Standard Retail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: \$29% Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) Except Specialty tier (up to 31-days supply) Catostrophic OOP Threshold: \$8,000 The plan pays the full cost for covered Part D drugs. Tier 3 and T1er 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply and \$105 for			Front 1.1		
nitial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 20-day supply for T3 and T4 at 3x copay, except Specialty Tier 5: 29%. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, sexcept Specialty Tier 1: \$0, Tier 2: \$12, Tier 3: \$42, Tier 3: \$47, Tier 4: \$100, Tier 5: 29%. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, sexcept Specialty Tier (up to 31-days supply) Preferred Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 29%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Preferred Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Preferred Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 3: \$47, Tier 3: \$47, Tier 4: \$100, Tier 5: 27%. Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Ti					
Tier 4: \$94, Tier 5: 29% Tier 4: \$94, Tier 5: 29% Tier 4: \$94, Tier 5: 29% Tier 4: \$90, Tier 4: \$91, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 29% Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, except Specialty tier (up to 31-days supply) Toverage Gap (Cost sharing is for up to 100-day supply for T3 and T4, Except Specialty tier (up to 31-days supply for T3 and T4, Tier 4: \$100, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$100, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier					
Addit Order: Cost sharing is for up to 100-day supply for T3 and T4 at 3x copa', except Specialty Tier 5. Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27% Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, \$100, Tier 5: \$2, Tier 4: \$100, Tier 5: 29% Tier 4: \$235, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 27% Preferred Mail: Tier 1: \$0, Tier 2: \$105, Tier 2: \$105, Tier 2: \$105, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 3: \$117.50, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 3: \$117.50, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$20, Tier 2: \$105, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$20, Tier 2: \$105, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Retail: Tier 1: \$2, Tier 3: \$105, Tier 4: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 27% Standard Retail: Tier 1: \$2, Tier 3: \$105, Tier 4: \$210, Tier 3: \$105, Tier 4: \$210, Tier 4: \$210, Tier 4: \$210, Tier 4: \$210, Tier 5: \$217, Tier 3: \$105, Tier 4: \$210, Tier 5: \$217, Tier 3: \$105, Tier 4: \$210, Tier 5: \$105, Tier 4: \$100, Tier 5: \$105, Tier 5: \$105, Tier 4: \$100, Tier 5: \$105, Tier 5	nitial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up				
Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, Tier 4: \$235, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$117.50, Tier 4: \$235, Tier 5: 29% Tier 4: \$235, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$117.50, Tier 4: \$250, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 3: \$105, Tier 4: \$250, Tier 3: \$105, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 4: \$250, Tier 5: 29% Standard Mail: Tier 1: \$0, Tier 4: \$250, Tier 5: 29%	90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47,	Standard Retail: Tier 1: \$9, Tier 2: \$17, Tier 3: \$47,		
for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) Coverage Gap (Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T1 and T2 and up to a 90-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply) Catastrophic OOP Threshold: \$8,000 IThe plan pays the full cost for covered Part D drugs. Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier 3: \$117.50, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 27% Generics (25% coinsurance) Brand (25% coinsurance) Brand (25% coinsurance) Brand (25% coinsurance including 70% discount) Catastrophic OOP Threshold: \$8,000 The plan pays the full cost for covered Part D drugs. Tier 3 and Tier 4 insulins (excludes deductible): \$35 for Tier 3 and Tier 4 insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or 31-day supply and \$105 for 90-day supply at a retail or	Mail Order: Cost sharing is for up to 100-day supply				
Coverage Gap (Cost sharing is for up to 100-day supply for T3 and T4, Brand (25% coinsurance) Brand (25% coinsurance) Brand (25% coinsurance) Brand (25% coinsurance including 70% discount) Brand (25% coinsurance including 70% discount) Catastrophic OOP Threshold: \$8,000 The plan pays the full cost for covered Part D drugs. The plan pays the full cost for covered Part D drugs. Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for Tier 3 and Tier 4 Insulins (excludes dedu	for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	Tier 4: \$235, Tier 5: 29% Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: \$117.50,	Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$22.50, Tier 2: \$42.50, Tier 3: \$117.50,		
except Specialty tier (up to 31-days supply)) Catastrophic OOP Threshold: \$8,000 The plan pays the full cost for covered Part D drugs. The plan pays the full cost for covered Part D drugs. The plan pays the full cost for covered Part D drugs. The plan pays the full cost for covered Part D drugs. Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for Coverage Gap stages 31-day supply and \$105 for 90-day supply at a retail or 31-day supply and \$105 for 90-day supply at a retail or	Coverage Gap (Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4,	Generics (25% coinsurance)	Generics (25% coinsurance)		
IRA Benefits — T3 and T4 offered through ICP and Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for Coverage Gap stages Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or 31-day supply and \$105 for 90-day supply at a retail or	except Specialty tier (up to 31-days supply))	, , ,	, , , , , , , , , , , , , , , , , , , ,		
Coverage Gap stages 31-day supply and \$105 for 90-day supply at a retail or 31-day supply and \$105 for 90-day supply at a retail or					
	IRA Benefits — T3 and T4 offered through ICP and		Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for		
	Coverage Gap stages	31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy			

	Senior Blue 651 HMO	Senior Blue Select HMO
\$0	\$115	\$52
\$0	\$0	\$0
Network: \$6,700; Catastrophic: N/A	Network: \$6,700; Catastrophic: N/A	Network: \$6,700; Catastrophic: N/A
\$0-\$5 Copay IN	\$0 Copay IN	\$0 Copay IN
\$45 Copay IN \$0 Lab Copay IN; \$45 Diagnostic test IN	\$25 Copay IN \$5 Lab Copay IN; \$40 Diagnostic test IN	\$30 Copay IN \$0 Lab Copay IN; \$50 Diagnostic test IN
\$0 Lab Copay IN; \$45 Diagnostic test IN	\$5 Lab Copay IN; \$40 Diagnostic test IN \$5 Lab Copay IN; \$40 Diagnostic test IN	\$0 Lab Copay IN; \$50 Diagnostic test IN
\$45 Copay IN	\$40 Copay IN	\$45 Copay IN
20% Coinsurance IN	20% Coinsurance IN	20% Coinsurance IN
\$150 Copay IN	\$150 Copay IN	\$175 Copay IN
\$0 Copay IN	\$0 Copay IN	\$0 Copay IN
\$15 Copay IN	\$15 Copay IN	\$25 Copay IN
\$45 Copay IN	\$25 Copay IN	\$30 Copay IN
\$15 Copay IN	\$15 Copay IN	\$25 Copay IN
\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
\$225 Copay IN	\$225 Copay IN	\$300 Copay IN
\$325 Copay IN	\$325 Copay IN	\$400 Copay IN
\$200 Copay	\$200 Copay	\$260 Copay
1200 00,000	Not Covered	,
	\$100 Copay	
	\$55 Copay	
\$290 per day for days 1–7, \$2,030 OOP Max per year	\$225 per day for days 1–7, \$1,575 OOP Max per year	\$335 per day for days 1–5, \$1,675 OOP Max per year
\$260 per day for days 1–6, \$1,560 OOP Max per year	\$215 per day for days 1–6, \$1,290 OOP Max per year	\$260 per day for days 1–6, \$1,560 OOP Max per year
	for days 1–20; \$203 per day for days 21–100. No yearly benefit period	
ÇO POT GU	\$0 Copay IN	
	ail or mail order pharmacy are limited to LifeScan and Roche. Contin. All other desired brands will need to be obtained from a Durable Med \$00 compression stockings, diabetic shoes/inserts; 20% all other items \$35 quarterly allowance	dicare Equipment (DME) provider (or an exception process).
	discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay	
100% for one medi per day for seven days upon		. Must be activated within 30 days of discharge.
	\$0 Onduo Virtual Diabetes Program	
	\$0 behavioral health care program	
\$0 progre	ım for COPD and congestive heart failure to manage condition throug	yh an app.
	Covered in Full	
	Services covered with applicable Copay listed for outpatient	
	surance for Part B rebatable drugs and 20% Coinsurance for all other	
	insurance up to a maximum of a \$35 copay for a one month supply of	
\$45 (except \$0 for diabetic retinal eye exam)	\$25 (except \$0 for diabetic retinal eye exam)	\$30 (except \$0 for diabetic retinal eye exam)
\$25 Copay IN	\$25 Copay IN	\$25 Copay IN
\$100 Allowance for routine eyewear	\$200 Allowance for routine eyewear	\$200 Allowance for routine eyewear
\$45 Copay IN	\$25 Copay IN	\$30 Copay IN
\$45 Copay IN (one every year)	\$45 Copay IN (one every year)	
		\$45 Copay IN (one every year)
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year)	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year)	Two hearing aids every year; TruHearing Advanced — \$499 copay. TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray; \$0 Copay IN (one every year)
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray; \$0 Copay IN (one every year) \$30 Copay IN
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year)	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year)	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray; \$0 Copay IN (one every year)
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics,	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics,	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics,
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits.	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits.	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits.	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits.
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits.	TruHearing Premium — \$799 capay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN (12 per plan year)	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year)
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Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN (three visits)	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN (12 per plan year) \$25 Copay IN \$25 Copay IN (three visits)	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN \$30 Copay IN
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN (12 per plan year) \$25 Copay IN \$25 Copay IN \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Partial Hospital: \$55 Copay IN
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN	TruHearing Premium — \$799 capay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN (12 per plan year) \$25 Copay IN \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN	Two hearing aids every year; TruHearing Ādvanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) S30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN
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Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: \$50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN \$15 Copay IN (12 per plan year) \$25 Copay IN \$25 Copay IN \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Part D Drugs Fundamental	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN \$30 Copay IN Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Fundamental
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Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X.Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN \$45 Copay IN Three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered	TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$25 Copay IN \$25 Copay IN (12 per plan year) \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Part D Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%	Two hearing aids every year; TruHearing Ādvanced — \$499 copay IruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN \$30 Copay IN Cardiac Rehab: \$15 Copay IN Period In Aspital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$175 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 30%
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN (here wisits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered Not Covered	TruHearing Premium — \$7.99 capay Office: \$0 Capay IN (two per year) Includes exam and cleaning X-Ray: \$0 Capay IN (one every year) \$25 Capay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Capay IN. See EOC for benefit limits. \$15 Capay IN. (12 per plan year) \$25 Capay IN \$25 Capay IN (12 per plan year) \$25 Capay IN (three visits) Cardiac Rehab: \$15 Capay IN Partial Hospital: \$55 Capay IN Outpatient Blood: \$0 Capay IN \$500 Part D Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47,	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$175 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: Fier 2: \$55, Tier 2: \$15, Tier 3: \$47,
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN \$45 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered Not Covered	TruHearing Premium — \$799 capay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN \$15 Copay IN (12 per plan year) \$25 Copay IN (12 per plan year) \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN 9500 Part D Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail: Tier 1: \$1, Tier 5: 33% Standard Mail: Tier 1: \$1, Tier 2: \$255, Tier 3: \$115, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$255, Tier 3: \$117.50,	Two hearing aids every year; TruHearing Ādvanced — \$499 copay IruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) S30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN \$30 Copay IN Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN S500 Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$175 Preferred Retail: Tier 1: \$7, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$10.5 Freferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$115, Freferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$115, Standard Mail: Tier 1: \$1, Tier 5: 30% Standard Mail: Tier 1: \$175, 0, Tier 2: \$25, Tier 3: \$117.50,
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN \$45 Copay IN \$45 Copay IN Quital Hospital: \$55 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered Not Covered Not Covered Not Covered	TruHearing Premium — \$799 capay Office: \$0 Capay IN (two per year) Includes exam and cleaning X-Ray: \$0 Capay IN (one every year) \$25 Capay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Capay IN. See EOC for benefit limits. \$15 Capay IN. (12 per plan year) \$25 Capay IN \$25 Capay IN (12 per plan year) \$25 Capay IN \$25 Capay IN (three visits) Cardiac Rehab: \$15 Capay IN Partial Hospital: \$55 Capay IN Outpatient Bload: \$0 Capay IN Outpatient Bload: \$0 Capay IN \$500 Part D Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$10, Tier 2: \$37,50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$10, Tier 2: \$37,50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 33% Generics (25% coinsurance) Brand (25% coinsurance)	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$175 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$105, Tier 4: \$235, Tier 5: 30% Standard Mail: Tier 1: \$17.50, Tier 2: \$25, Tier 3: \$175, Tier 4: \$255, Tier 5: 30% Standard Mail: Tier 1: \$17.50, Tier 2: \$37.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 30% Generics (25% coinsurance) Brand (25% coinsurance) Brand (25% coinsurance)
Two hearing aids every year; TruHearing Advanced — \$599 copay; TruHearing Premium — \$899 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$45 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: \$50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (six per plan year) \$45 Copay IN \$45 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$250 Not Covered Not Covered Not Covered	TruHearing Premium — \$7.99 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$25 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN. (12 per plan year) \$25 Copay IN \$25 Copay IN \$25 Copay IN \$25 Copay IN (three visits) Cardiac Rehab: \$15 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN Outpatient Blood: \$0 Copay IN \$500 Part D Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$10, Tier 2: \$37.50, Tier 3: \$17.50, Tier 4: \$255, Tier 5: 33% Standard Mail: Tier 1: \$1, 50, Tier 2: \$37.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 33% Generics (25% coinsurance)	Two hearing aids every year; TruHearing Advanced — \$499 copay TruHearing Premium — \$799 copay Office: \$0 Copay IN (two per year) Includes exam and cleaning X-Ray: \$0 Copay IN (one every year) \$30 Copay IN Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits. \$15 Copay IN (12 per plan year) \$30 Copay IN \$30 Copay IN \$30 Copay IN Partial Hospital: \$55 Copay IN Partial Hospital: \$55 Copay IN Outpatient Blood: \$0 Copay IN \$500 Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$175 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$7, Tier 2: \$5, Tier 3: \$105, Tier 4: \$235, Tier 5: 30% Preferred Mail: Tier 1: \$5, Tier 2: \$35. Fier 3: \$117.50, Tier 4: \$235, Tier 5: 30% Generics (25% coinsurance)

Highmark Blue Cross Blue Shield of Western New York PPO



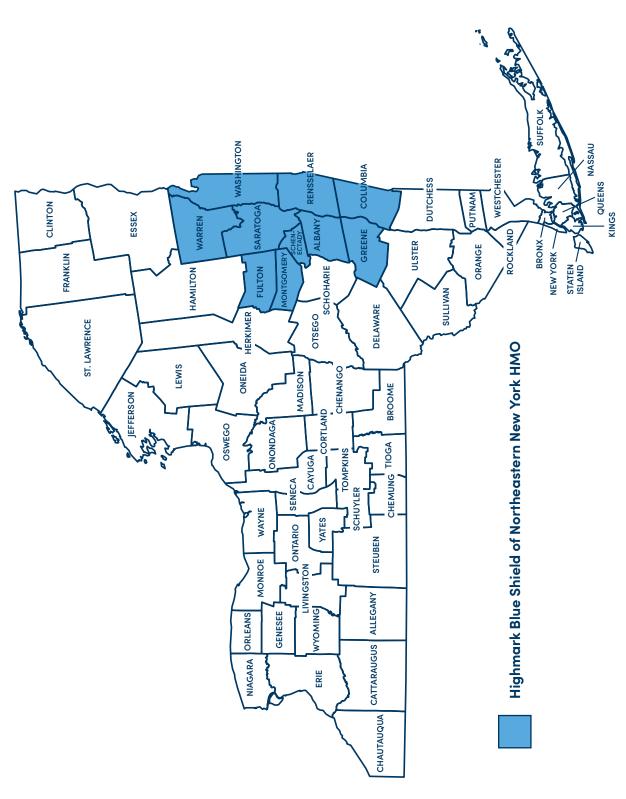
^{*}Pricing is subject to CMS approval

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

	Freedom Nation PPO
Monthly Plan Premium	\$24
Part B Premium Giveback	\$4
Out-of-Pocket Maximum	Network: \$6,750; Catastrophic: \$11,300
PCP Office Visit	\$0 Copay IN; 50% Coinsurance OON
Specialist Office Visit	\$30 Copay IN; 50% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$5 Lab Copay IN; \$50 Diagnostic Tests IN; Lab \$5 Copay OON; Dignostic Test 50% Coinsurance OON
Lab and Diagnostic Tests (Outpatient Facility)	\$5 Lab Copay IN; \$50 Diagnostic Tests IN; Lab \$5 Copay OON; Dignostic Test 50% Coinsurance OON
X-Rays	\$50 Copay IN; 50% Coinsurance OON 20% Coinsurance IN; 50% Coinsurance OON
Radiation Therapy Advanced Imaging	\$200 Copay IN; 50% Coinsurance OON
Preventive/Screening	\$0 Copay IN; 50% Coinsurance OON
Outpatient Physical and Speech Therapy	\$25 Copay IN; 50% Coinsurance OON
Medicare Covered Acupuncture	\$30 Copay IN; 50% Coinsurance OON
Outpatient Occupational Therapy	\$25 Copay IN; 50% Coinsurance OON
Outpatient Mental Health	\$40 Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse	\$40 Copay IN; 50% Coinsurance OON
Outpatient Surgical (Includes Observation)	\$275 Copay IN; 50% Coinsurance OON
	\$375 Copay IN; 50% Coinsurance OON
Ambulance	\$300 Copay
Transportation	Not Covered
Emergency Room	\$100 Copay
Urgent Care Inpatient Hospital Stay	\$55 Copay
(COVID-19 cost share waiver has been removed)	\$370 per day for days 1–5, \$1,850 OOP Max per year IN; 50% Coinsurance OON
Inpatient Psychiatry Stay	\$370 per day for days 1–5, \$1,850 OOP Max per year IN; 50% Coinsurance OON
Skilled Nursing Facility	\$0 per day for days 1–20; \$203 per day for days 21–100,
<u> </u>	No yearly benefit period maximum IN; 50% Coinsurance OON
Home Health	\$0 Copay IN; 50% Coinsurance OON
Diabetic Supplies and Services	\$0 Copay IN; 50% Coinsurance OON
	Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to LifeScan and Roche. Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom.
	Continuous glucose monitors, sensors and transmitters aispensed via retail or mail order pnarmacy are imited to Abboti and Descont. 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 IN; 50% Coinsurance OON
OTC	\$40 quarterly allowance
Meal Benefit	100% for one meal per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay.
	Must be activated within 30 days of discharge.
Onduo	\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.
Fitness Benefit Additional Telehealth Services	Covered in Full IN; 50% Coinsurance after satisfying a \$500 Deductible OON
Part B Drugs — Chemotherapy and All Other Part B	Services covered with applicable Copay listed for outpatient
Part B Drugs — Insulin	0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 50% Coinsurance OON
Fair b brugs — ilisullii	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; 50% Coinsurance OON
Medicare Covered Vision (Office Visit)	\$30 (except \$0 for diabetic retinal eye exam); 50% Coinsurance OON
Routine Vision (Office Visit)	\$25 Copay IN; 20% Coinsurance OON
Routine Vision (Eyewear)	\$100 Allowance for routine eyewear
Medicare Covered Hearing Exam	\$30 Copay IN; 50% Coinsurance OON
Routine Hearing Exam	\$45 Copay (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay
Routine Dental	Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, cleaning and flouride treatment
Rounne Delliul	Office: 50 Copay IN; 50 Copay OON (two per year) includes exam, cleaning and nouride frediment X-Ray: \$0 Copay IN (one every year); \$0 Copay OON
Medicare Covered Comprehensive Dental	\$30 Copay IN; 50% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics,
	Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.
Medicare Covered Chiropractic	\$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic	\$15 Copay IN (six per plan year); 50% Coinsurance OON
Medicare Covered Podiatry Routine Podiatry	\$30 Copay IN; 50% Coinsurance OON \$30 Copay IN; 50% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET,	Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON
Partial Hospital, Outpatient Blood	Partial Hospital: \$55 copay IN; 50% Coinsurance OON
	Outpatient Blood: 80 Coppy IN; 50% Coinsurance OON
Combined Acupuncture and Massage Therapy Allowance	\$250
	Part D Drugs
Formulary	Fundamental
Deductible	Tier 1–Tier 3: \$0, Tier 4–Tier 5: \$200
Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up	Preferred Retail: Tier 1: \$0, Tier 2: \$5, Tier 3: \$42, Tier 4: \$94, Tier 5: 29%
to 31-day supply. Can get up to 100-day supply for T1 and T2 and	Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$54, Tier 5: 29% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 29%
90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	
Mail Order: Cost sharing is for up to 100–day supply for T1 and T2 and up to a 90–day supply for T3 and T4, except Specialty tier	Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 29%
(up to 31 days supply)	Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 29%
Coverage Gap (Cost sharing is for up to 100-day supply	Consideration :
for T1 and T2 and up to a 90-day supply for T3 and T4, except	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
Specialty tier (up to 31 days supply))	· · · · · · · · · · · · · · · · · · ·
Catastrophic OOP Threshold: \$8,000	The plan pays the full cost for covered Part D drugs.
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Tier 3 and Tier 4 Insulins (excludes deductible): \$35 for 31-day supply and \$105 for 90-day supply at a retail or mail order pharmacy

Forever Blue Value PPO	Forever Blue 751 PPO
\$144	\$209
\$0	\$0
Network: \$6,700; Catastrophic: \$10,000	Network: \$6,700; Catastrophic: \$10,000
\$0-\$10 Copay IN; 35% Coinsurance OON	\$0-\$5 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
\$5 Lab Copay IN; \$45 Diagnostic Tests; Both 35% Coinsurance OON \$5 Lab Copay IN; \$45 Diagnostic Tests; Both 35% Coinsurance OON	\$5 Lab Copay IN; \$40 Diagnostic Tests; Both 25% Coinsurance OON \$5 Lab Copay IN; \$40 Diagnostic Tests; Both 25% Coinsurance OON
\$45 Copay IN; \$45 Diagnostic Tests; Both 35% Coinsurance OON	\$40 Copay IN; 25% Coinsurance OON
20% Coinsurance IN; 35% Coinsurance OON	20% Coinsurance IN; 25% Coinsurance OON
\$150 Copay IN; 35% Coinsurance OON	\$150 Copay IN; 25% Coinsurance OON
\$0 Copay IN; 35% Coinsurance OON	\$0 Copay IN; 25% Coinsurance OON
\$20 Copay IN; 35% Coinsurance OON	\$20 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
\$20 Copay IN; 35% Coinsurance OON	\$20 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 50% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 50% Coinsurance OON
\$250 Copay IN; 35% Coinsurance OON	\$200 Copay IN; 25% Coinsurance OON
\$350 Copay IN; 35% Coinsurance OON	\$300 Copay IN; 25% Coinsurance OON
\$250 Copay	\$225 Copay
	overed
	Copay Copay
\$250 per day for days 1-7, \$1,750 OOP Max per year IN; 35% Coinsurance OON \$270 per day for days 1-6, \$1,620 OOP Max per year IN; 35% Coinsurance OON	\$205 per day for days 1-7, \$1,435 OOP Max per year IN; 30% Coinsurance OON \$270 per day for days 1-6, \$1,620 OOP Max per year IN; 30% Coinsurance OON
	yearly benefit period maximum IN; 50% Coinsurance OON
\$0 Copay IN; 35% Coinsurance OON	\$0 Copay IN; 25% Coinsurance OON
Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy ar via retail or mail order pharmacy are limited to Abbott and Dexcom. All other desired brands will r	Coinsurance OON I limited to LifeScan and Roche. Continuous glucose monitors, sensors and transmitters dispensed eed to be obtained from a Durable Medicare Equipment (DME) provider (or an exception process).
	ts; 20% all other items IN; 50% Coinsurance OON
\$35 quarterly allowance	\$35 quarterly allowance
100% for one meal per day for seven days upon discharge from an inpatient hospi	tal, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.
\$0 Onduo Virtual	Diabetes Program
	alth care program
	failure to manage condition through an app.
	fter satisfying a \$500 Deductible OON
Services covered with applica	ble Copay listed for outpatient
0%—19,99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 35% Coinsurance OON 20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; 35% Coinsurance OON	0%—19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON 20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin IN; 25% Coinsurance OON
\$30 (except \$0 for diabetic retinal eye exam); 35% Coinsurnace OON	\$25 (except \$0 for diabetic retinal eye exam); 25% Coinsurance OON
	Coinsurance OON
\$200 Allowance for routine eyewear	\$200 Allowance for routine eyewear \$25 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	ne every year)
Two hearing aids every year; TruHearing Advanced — \$499 Copay;	Two hearing aids every year; TruHearing Advanced — \$499 copay;
TruHearing Premium – \$799 copay	TruHearing Premium — \$799 copay
Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON	Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON
\$30 Copay IN; 35% Coinsurance OON	\$25 Copay IN; 25% Coinsurance OON
Comprehensive maximum allowance of \$2000	Comprehensive maximum allowance of \$2000
Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.	Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.
\$15 Copay IN; 35% Coinsurance OON	\$15 Copay IN; 25% Coinsurance OON
\$15 Copay IN (12 per plan year); 25% Coinsurance OON	\$15 Copay IN (12 per plan year); 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON	\$15 Copay IN (12 per pian year); 25% Coinsurance OON \$25 Copay IN; 25% Coinsurance OON
\$30 Copay IN; 35% Coinsurance OON (three visits)	\$25 Copay IN; 25% Coinsurance OON (three visits)
Cardiac Rehab: \$5 Copay IN; 35% Coinsurance OON	Cardiac Rehab: \$15 Copay IN: 25% Coinsurance OON
Partial Hospital: \$55 copay IN; 35% Coinsurance OON	Partial Hospital: \$55 copay IN; 25% Coinsurance OON
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Drugs
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Prugs Fundamental
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Drugs
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Prugs Fundamental
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental \$0 Preferred Retail: Tier 1: \$4, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33%	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Prugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 33%
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental \$0 Preferred Retail: Tier 1: \$4, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$9, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33%	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Prugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$13, Tier 3: \$47, Tier 4: \$99, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 33%
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental \$0 Preferred Retail: Tier 1: \$4, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$9, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tier 3: \$105, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 5: 37.50, Tie	Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Prugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$13, Tier 3: \$47, Tier 4: \$99, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$32.50, Tier 3: \$117.50, Tier 4: \$247.50, Tier 5: 33% Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
Outpatient Blood: \$0 Copay IN; 35% Coinsurance OON \$500 Part D Fundamental \$0 Preferred Retail: Tier 1: \$4, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$9, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$22.50, Tier 2: \$37.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33% Generics (25% coinsurance) Brand (25% coinsurance including 70% discount) The plan pays the full cos	Outpatient Blood: \$0 Copay IN; 25% Cainsurance OON \$500 Prugs Fundamental S0 Preferred Retail: Tier 1: \$2, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$13, Tier 3: \$47, Tier 4: \$99, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$20, Tier 3: \$105, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$32.50, Tier 3: \$117.50, Tier 4: \$247.50, Tier 5: 33% Generics (25% coinsurance)

Highmark Blue Shield of Northeastern New York HMO

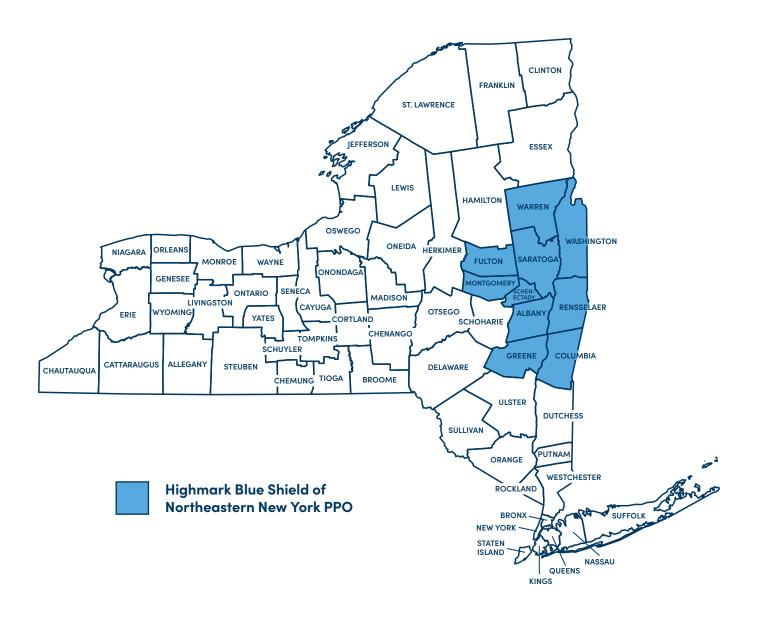


*Pricing is subject to CMS approval

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

Monthly Plan Premium	08	\$53	\$122
Part B Premium Giveback	\$8	0\$	0\$
Out-of-Pocket Maximum	Network: \$6,750; Catastrophic: N/A	Network: \$6,700; Catastrophic: N/A	Network: \$6,700; Catastrophic: N/A
PCP Office Visit	\$0 Copay IN	\$0-\$10 Copay IN	\$0 Copay IN
Specialist Office Visit	\$35 Copay IN	\$35 Copay IN	\$26 Copay IN
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$5 lab Copay IN; \$50 diagnostic test copay IN
Lab and Diagnostic Tests (Outpatient Facility)	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$10 lab Copay IN; \$50 diagnostic test copay IN	\$5 lab Copay IN; \$50 diagnostic test copay IN
A-rays	NI Communication (NIC)	20% Colonia IN	Sou Copay IN
Advanced Imagina	NI SOU COS	N. VOO OOS	
Preventive/Screening	\$0 Coppy IN	\$0 Copdy IN	\$0 Copay IN
Outpatient Physical and Speech Therapy	\$30 Copay IN	\$25 Copay IN	\$15 Copay IN
Medicare Covered Acupuncture	\$35 Copay IN	\$35 Copay IN	\$26 Copay IN
Outpatient Occupational Therapy	\$30 Copay IN	\$25 Copay IN	\$15 Copay IN
Outpatient Mental Health	\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
Outpatient Substance Abuse	\$40 Copay IN	\$40 Copay IN	\$40 Copay IN
Outpatient Surgical (Includes Observation)	\$275 Copay IN	\$230 Copay IN	\$200 Copay IN
-	\$375 Copay IN	\$330 Copay IN	\$300 Copay IN
Ambulance	\$290 Copay	\$300 Copay	\$200 Copay
Iransportation		Not Covered	
Emergency Room		SIOU COPAY	
Inpatient Hospital Stay	\$375 per day for days 1–5, \$1,875 OOP Max per year	\$325 per day for days 1–4, \$1,300 OOP Max per year	\$225 per day for days 1-7, \$1,575 OOP Max per year
(COVID-19 cost share walver has been removed)	\$310 per day for days 1–6. \$1,860 OOP Max per year	\$275 per day for days 1–6. \$1.650 OOP Max per year	\$260 per day for days 1–6. \$1.560 OOP Max per year
Skilled Nursing Facility	\$0 per day	\$0 per day for days 1–20, \$203 per day for days 21–100. No yearly benefit period maximum	I maximum.
Home Health Diabetic Supplies and Services	Diabetic glucometer, test strip, and lancet brands dispensed via ret or mail order pharmacy are limited to Abbott and Dexcom.	\$0 Copay IN Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to the Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are limited from a Durable Medicare Equipment (DME) provider for an exception process).	uous glucose monitors, sensors and transmitters dispensed via dicare Equipment (DME) provider (or an exception process).
Durable Medical Equipment		\$0 compression stockings, diabetic shoes/inserts; 20% all other items	
OTC	\$25 quarterly allowance	\$35 quarterly allowance	\$35 quarterly allowance
Meal Benefit	\$0 copay, One meal per day for seven days upor	\$0 copay, One meal per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.	xy. Must be activated within 30 days of discharge.
Onduo		\$0 Onduo Virtual Diabetes Program	
Spring Health		\$0 behavioral health care program	
CHF and COPD Management powered by Vida	S0 progre	\$0 program for COPD and congestive heart failure to manage condition through an app.	ghan app.
Additional Telebealth Services		Services covered with applicable Congy listed for purportient	
Part B Drugs — Chemotherany and All Other Part B	100 404 D1-40	Coinsurance for Part Brehatable duras and 30% Coinsurance for all other Part B duras IN	r Part B dries IN
Part B Drugs — Insulin	20% Cc	20% Coinsurance up to a maximum of a \$35 copay for a one month supply of insulin	finsulin
Medicare Covered Vision (Office Visit)	\$35 (except \$0 for diabetic retinal eye exam)	\$35 (except \$0 for diabetic retinal eye exam)	\$26 (except \$0 for diabetic retinal eye exam)
Routine Vision (Office Visit)		\$25 Copay IN; Benefit is carved out to Davis Vision	
Routine Vision (Eyewear)	\$100 Allowance IN; Benefit is carved out to Davis Vision	\$200 Allowance IN; Benefit is carved out to Davis Vision	\$200 Allowance IN; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	\$35 Copay IN	\$35 Copay IN	
Routine Hearing Exam Routine Hearing (Hearing Aids)	Two hearing aids every year; TruHearing Advanced — \$599 copay;	Two hearing aids every year, TruHearing Advanced — \$499 copay;	Two hearing aids every year; TruHearing Advanced — \$499 copay;
Routine Dental	iruhedring Premium — 5899 copay Office: \$0 Cop	Irunearing Premium — 5/99 copay VIX (two pervear) Includes exam and cleaning: X-Bay: \$0 Copay IX (Irunearing Premium — \$799 copay
Medicare Covered Comprehensive Dental	\$35 Copdy IN	\$35 Copay IN	\$26 Copay IN
Dental Allowance — Preventive and/or Comprehensive		Comprehensive maximum allowance of \$2000	/
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Extraction	storative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. Periodontal cleanings \$0 Copay IN. See EOC for benefit limits	ings \$0 Copay IN. See EOC for benefit limits.
Medicare Covered Chiropractic		\$15 Copay IN	
Routine Chiropractic	\$15 Copay IN (six per plan year)	\$15 Copay IN (12 per plan year)	\$15 Copay IN (12 per plan year)
Medicare Covered Podiatry	\$35 Copay IN	\$35 Copay IN	\$26 Copay IN
Routine Podiatry	\$35 Copay IN (three visits)	\$35 Copay IN (three visits)	\$26 Copay IN (three visits)
Cardiac and Pulmonary Rehab and SET,	Cardiac Rehab: \$15 Copay IN; Partial Hospital:	Cardiac Rehab: \$15 Copay IN; Partial Hospital:	Cardiac Rehab: \$10 Copay IN; Partial Hospital:
Combined Actionincture and Massage Therapy Allowance	\$250 Copay III, Calpanelli Blood, to Copay III	0.500000000000000000000000000000000000	SEOO CO COCA COCA COCA COCA COCA COCA COC
	Part	D Drugs	
Formulary	Findamental	1	Findamental
Deductible	Tier1–Tier2: \$0, Tier 3–Tier 5: \$295	Tier1-Tier 2: \$0, Tier 3-Tier 5: \$275	0%
tial Coverage Period Limit: \$5,030. Retail: Cost sharing is	Preferred Retail: Tier 1: \$3, Tier 2: \$10, Tier 3: \$42,	Preferred Retail: Tier 1: \$2, Tier 2: \$8, Tier 3: \$42,	Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42,
tor up to 31–day supply. Can get up to 100–day supply for 11 and T2 and 90–day supply for T3 and T4 at 3x copay, except Specialty Tier 5.	lier 4: 594, lier 5: 28% Standard Retail: Tier 1: 58, Tier 2: 515, Tier 3: \$47, Tier 4: \$100, Tier 5: 28%	Her 4: 594, Her 5: 28% Standard Retail: Tier 1: 57, Tier 2: 513, Tier 3: 547, Tier 4: \$100, Tier 5: 28%	lier 4: 594 , lier 5: 33% Standard Retail: Tier 1: 57 Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33%
Mail Order: Cost sharing is for up to 100-day supply for T and T2 and up to a 90-day supply for T3 and T4,	Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 5: \$25, Ti	Preferred Mail: Tier 1: S0, Tier 2: \$20, Tier 3: \$105, Chanded Mail: Tier 4: \$255 Tier 5: \$20 En Tier 9: \$20	Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$135, Tier 5: 33%.
(Aldhes short on the limit deposits of the l	Tier 4: \$250, Tier 5: \$3%, Tier 5: \$17.50,	Januara Main. 1611. 37.30, 11et 2. 35.30, 11et 3. 317.30, Tier 4: \$250, Tier 5: 28%	Januaria Mail: 11er 1: 317.30, 11er 5: 33% Tier 4: \$250, Tier 5: 33%
Coverage cap (Lost snaring is for up to 100-aay supply for T1 and T2 and up to a 90-aay supply for T3 and T4, except Speciality tier (up to 31-aays supply).	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)	Generics (25% coinsurance) Brand (25% coinsurance including 70%	Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)
atastrophic OOP Threshold: \$8,000		The plan pays the full cost for covered Part D drugs.	
CONT. 1 2 22 2 1 2 22 2 1 2 2 2 2 2 2 2 2 2			

Highmark Blue Shield of Northeastern New York PPO



^{*}Pricing is subject to CMS approval

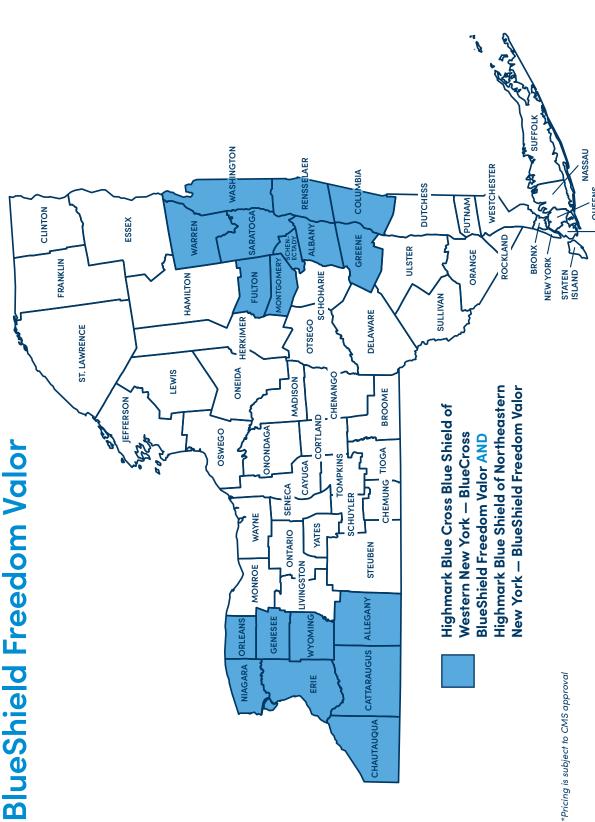
Highmark Blue Shield of Northeastern New York PPO (Products and pricing by county)

	Freedom Nation PPO
Monthly Plan Premium	\$0
Part B Premium Giveback	\$8
Out-of-Pocket Maximum	Network: \$6,750; Catastrophic: \$11,300
PCP Office Visit	\$0 Copay IN; 40% Coinsurance OON
Specialist Office Visit	\$30 Copay INN; 40% Coinsurance OON
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$5 lab Copay IN; \$5 copay OON
	\$50 diagnostic test copay IN; 50% Coinsurance OON
Lab and Diagnostic Tests (Outpatient Facility)	\$5 lab Copay IN; \$5 copay OON \$50 diagnostic test copay IN; 50% Coinsurance OON
X-Rays	\$50 Copay IN; 50% Coinsurance OON
Radiation Therapy	20% Coinsurance IN; 50% Coinsurance OON
Advanced Imaging	\$200 Copay IN; 50% Coinsurance OON
Preventive/Screening	\$0 Copay IN; 40% Coinsurance OON
Outpatient Physical and Speech Therapy	\$30 Copay IN; 50% Coinsurance OON
Medicare Covered Acupuncture	\$30 Copay IN; 40% Coinsurance OON
Outpatient Occupational Therapy	\$30 Copay IN; 50% Coinsurance OON
Outpatient Mental Health	\$40 Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse	\$40 Copay IN; 50% Coinsurance OON
Outpatient Surgical (Includes Observation)	ASC: \$225 Copay IN; 50% Coinsurance OON
	Facility: \$325 Copay IN; 50% Coinsurance OON
Ambulance	\$310 Copay
Transportation	Not Covered
Emergency Room	\$100 Copay
Urgent Care	\$55 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	\$375 per day (days 1–5) IN, \$1,875 OOP Max per year; 50% per stay OON; OON: 50% Coinsurance
Inpatient Psychiatry Stay	INN: \$370 per day for days 1–5, \$1,850 OOP Max per year; OON: 50% Coinsurance
Skilled Nursing Facility	
owned training racinity	INN: \$0 per day for days 1–20; \$203 per day for days 21–100, No yearly benefit period maximum. OON: 50% Coinsurance
Home Health	\$0 Copay IN; 50% Coinsurance OON
Diabetic Supplies and Services	\$0 Copay IN; Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to
	LifeScan and Roche. Continuous glucose monitors, sensors and transmitters dispensed via retail or mail order pharmacy are
	limited to Abbott and Dexcom. All other desired brands will need to be obtained from a Durable Medicare Equipment (DME)
D. II M. P. IE. 1	provider (or an exception process); 50% coinsurance OON
Durable Medical Equipment	INN: \$0 compression stockings, diabetic shoes/inserts; 20% all other items. OON: 50% Coinsurance
ОТС	\$25 Allowance Once Per Quarter IN
Meal Benefit	\$0 copay, one meal per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay.
Medi Belletti	Must be activated within 30 days of discharge.
Onduo	\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral health care program
CHF and COPD Management powered by Vida	\$0 program for COPD and congestive heart failure to manage condition through an app.
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 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; 50% Coinsurance OON
Medicare Covered Vision (Office Visit)	\$30 (except \$0 for diabetic retinal eye exam); 40% coinsurance OON
Routine Vision (Office Visit)	\$25 Copay IN; 20% coinsurance OON; Benefit is carved out to Davis Vision
Routine Vision (Eyewear)	\$100 Allowance IN and OON Combined; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	\$30 Copay IN; 40% Coinsurance OON
Routine Hearing Exam	\$45 Copay (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year; TruHearing Advanced — \$699 copay; TruHearing Premium — \$999 copay
Routine Dental	Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, cleaning and flouride treatment
	X-Ray: \$0 Copay IN (one every year); \$0 Copay OON
Medicare Covered Comprehensive Dental	\$30 Copay IN; 40% Coinsurance OON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2000
Comprehensive Dental — Supplemental	Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics,
	Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.
	Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.
	\$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON
Routine Chiropractic Medicare Covered Podiatry	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits)
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET,	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits)
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 40% Coinsurance OON
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON S250 Part D Drugs
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit; \$5,030. Retail: Cost sharing is for up to 31-day supply, Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$125 Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 30% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 30%
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4,	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$125 Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 30%
Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, except Specialty tier (up to 31-days supply) Coverage Gap (Cost sharing is for up to 100-day supply Coverage Gap (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	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 40% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$125 Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 30% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 30%
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$125 Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$100, Tier 5: 30% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 30% Standard Mail: Tier 1: \$12.50, Tier 2: \$42.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 30%
Routine Chiropractic Medicare Covered Podiatry Routine Podiatry Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood Combined Acupuncture and Massage Therapy Allowance Formulary Deductible Initial Coverage Period Limit: \$5,030. Retail: Cost sharing is for up to 31-day supply. Can get up to 100-day supply for T1 and T2 and 90-day supply for T3 and T4 at 3x copay, except Specialty Tier 5. Mail Order: Cost sharing is for up to 100-day supply for T3 and T4, except Specialty Tier (up to 31-days supply) Coverage Gap (Cost sharing is for up to 100-day supply for T3 and T4, except Specialty Tier (up to 31-days supply) Coverage Gap (Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day supply for T3 and T4, except Specialty tier (up to 31-days supply)	\$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (six per plan year); 50% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON \$30 Copay IN; 40% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$250 Part D Drugs Fundamental Tier 1-Tier 3: \$0, Tier 4-Tier 5: \$125 Preferred Retail: Tier 1: \$0, Tier 2: \$8, Tier 3: \$42, Tier 4: \$94, Tier 5: 30% Standard Retail: Tier 1: \$5, Tier 2: \$17, Tier 3: \$47, Tier 4: \$94, Tier 5: 30% Preferred Mail: Tier 1: \$0, Tier 2: \$0, Tier 3: \$105, Tier 4: \$235, Tier 5: 30% Standard Mail: Tier 1: \$0, Tier 2: \$42.50, Tier 3: \$17.50, Tier 4: \$250, Tier 5: 30% Generics (25% coinsurance) Brand (25% coinsurance including 70% discount)

Freedom Basic PPO	Forever Blue 770 PPO
\$0	\$206
\$57	\$0
Network: \$8,300; Catastrophic: \$12,450	Network: \$6,700; Catastrophic: \$10,000
\$0-\$10 Copay IN; 50% Coinsurance OON	\$0-\$5 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON \$10 lab Copay IN; \$10 copay OON	\$22 Copay IN; 25% Coinsurance OON
\$50 diagnostic test copay IN; 50% Coinsurance OON	\$5 lab Copay IN; \$5 copay OON \$40 diagnostic test copay IN; 25% Coinsurance OON
\$10 lab Copay IN; \$10 copay OON	\$5 lab Copay IN; \$5 copay OON
\$50 diagnostic test copay IN; 50% Coinsurance OON	\$40 diagnostic test copay IN; 25% Coinsurance OON
\$50 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 25% Coinsurance OON
20% Coinsurance IN; 50% Coinsurance OON	20% Coinsurance IN; 25% Coinsurance OON
\$200 Copay IN; 50% Coinsurance OON	\$150 Copay IN; 25% Coinsurance OON
\$0 Copay IN; 50% Coinsurance OON	\$0 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$15 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$22 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$15 Copay IN; 25% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 50% Coinsurance OON
\$40 Copay IN; 50% Coinsurance OON	\$40 Copay IN; 50% Coinsurance OON
\$425 Copay IN; 50% Coinsurance OON	\$175 Copay IN; 25% Coinsurance OON
\$475 Copay IN; 50% Coinsurance OON \$305 Copay	\$275 Copay IN; 25% Coinsurance OON \$200 Copay
	povered
	Copay
\$55 C	Copay
INN: \$400 per day for days 1–5, \$2,000 OOP Max per year; OON: 50% Coinsurance	INN: \$205 per day for days 1-7, \$1,435 OOP Max per year; OON: 30% Coinsurance
INN: \$395 per day for days 1–4, \$1,580 OOP Max per year; OON: 50% Coinsurance	INN: \$270 per day for days 1–6, \$1,620 OOP Max per year; OON: 30% Coinsurance
INN: \$0 per day for days 1–20; \$203 per day for days 21–100,	INN: \$0 per day for days 1–20; \$203 per day for days 21–100,
No yearly benefit period maximum. OON: 50% Coinsurance	No yearly benefit period maximum. OON: 30% Coinsurance \$0 Copay IN; 25% Coinsurance OON
\$0 Copay IN; 50% Coinsurance OON	
transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom. All of	rder pharmacy are limited to LifeScan and Roche. Continuous glucose monitors, sensors and ther desired brands will need to be obtained from a Durable Medicare Equipment (DME) provider s); 50% coinsurance OON
INN: \$0 compression stockings, diabetic shoes/ir	serts; 20% all other items; OON: 50% Coinsurance
Not Covered	\$35 quarterly allowance
\$0 copay, one meal per day for seven days upon discharge from an inpatient hosp	ital, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.
\$0 Onduo Virtual	Diabetes Program
	alth care program
	failure to manage condition through an app.
	fter satisfying a \$500 Deductible OON
	ble Copay listed for outpatient
0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 50% Coinsurance OON	0%–19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON
20% Coinsurance up to a maximum of a \$35 copay for	a one month supply of insulin IN; 50% Coinsurance OON
\$40 (except \$0 for diabetic retinal eye exam); 50% coinsurance OON	\$22 (except \$0 for diabetic retinal eye exam); 25% coinsurance OON
	l; Benefit is carved out to Davis Vision
Not Covered	\$200 Allowance IN and OON Combined; Benefit is carved out to Davis Vision
\$40 Copay IN; 50% Coinsurance OON	\$22 Copay IN; 25% Coinsurance OON
Not Covered	
Not Covered	\$45 Copay (one every year)
Noi Covered	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning
	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray; \$0 Copay IN (one every year); \$0 Copay OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50%
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurances OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON, Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits.	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits.
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN (3 per plan year); 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 30 Palan year); 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits)	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray; \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON (three visits) Cardiac Rehab: \$15 Copay IN; 25% Coinsurance OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits) Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay ON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Partial Hospital: \$15 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 Copay IN; 25% Coinsurance OON
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 3 per plan year); 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits) Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay ON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Cardiac Rehab: \$15 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON
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Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 30% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$100 Part D Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$350 Preferred Retail: Tier 1: \$0, Tier 2: \$14, Tier 3: \$42, Tier 4: \$94, Tier 5: 27%	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON \$500 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33%
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics: \$0% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$20 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits) Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON \$100 Part D Fundamental Tier 1-Tier 2: \$0, Tier 3: \$14, Tier 3: \$42, Tier 4: \$94, Tier 5: 27% Standard Retail: Tier 1: \$7, Tier 2: \$19, Tier 3: \$47, Tier 4: \$235, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 2: \$47, 50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 2: \$47,50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 27%	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (none every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 Copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON S500 Drugs Fundamental \$0 Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$7, Tier 2: \$15, Tier 3: \$47, Tier 4: \$100, Tier 5: 33% Preferred Mail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$105, Tier 4: \$235, Tier 5: 33%
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 50% Coinsurance IN, 50% Coinsurance OON, Periodontal cleanings \$20 Copay IN and OON, See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits) Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$100 Part D Fundamental Tier 1-Tier 2: \$0, Tier 2: \$14, Tier 3: \$42, Tier 4: \$94, Tier 5: 27% Standard Retail: Tier 1: \$0, Tier 2: \$19, Tier 3: \$47, Tier 4: \$94, Tier 5: 27% Standard Retail: Tier 1: \$0, Tier 2: \$19, Tier 3: \$17, 50, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 2: \$47, 50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 27% Standard Mail: Tier 1: \$17,50, Tier 2: \$47,50, Tier 3: \$117,50, Tier 4: \$250, Tier 5: 27%	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (none every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 25% Coinsurance OON \$15 Copay IN (12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON Preferred Retail: Tier 1: \$2, Tier 2: \$10, Tier 3: \$42, Tier 4: \$94, Tier 5: 33% Standard Retail: Tier 1: \$0, Tier 2: \$25, Tier 3: \$47, Tier 4: \$235, Tier 5: 33% Standard Mail: Tier 1: \$0, Tier 2: \$37.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33% Standard Mail: Tier 1: \$17.50, Tier 2: \$27.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 33%
Office: \$20 Copay IN; \$20 copay OON (two per year) Includes exam, cleaning and flouride treatment X-Ray: \$20 Copay IN (one every year); \$20 copay OON \$40 Copay IN; 50% Coinsurance OON Combined maximum allowance of \$1000 Restorative Services, Endodontics, Prosthodontics, Other Oral/Maxillofacial Surgery, Extractions, Non-Routine Services, Diagnostics, Periodontics, 50% Coinsurance IN, 50% Coinsurance OON, Periodontial cleanings \$20 Copay IN and OON, See EOC for benefit limits. \$15 Copay IN; 50% Coinsurance OON \$15 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON \$40 Copay IN; 50% Coinsurance OON (three visits) Cardiac Rehab: \$10 Copay IN; 50% Coinsurance OON Partial Hospital: \$55 copay IN; 50% Coinsurance OON Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON \$100 Part D Fundamental Tier 1-Tier 2: \$0, Tier 3-Tier 5: \$350 Preferred Retail: Tier 1: \$0, Tier 2: \$19, Tier 3: \$42, Tier 4: \$94, Tier 5: 27% Standard Retail: Tier 1: \$0, Tier 2: \$19, Tier 3: \$47, Tier 4: \$25, Tier 5: 27% Standard Mail: Tier 1: \$0, Tier 2: \$47.50, Tier 3: \$117.50, Tier 4: \$250, Tier 5: 27% Generics (25% coinsurance) Brand (25) The plan pays the full cost	Two hearing aids every year; TruHearing Advanced — \$499 copay; TruHearing Premium — \$799 copay Office: \$0 Copay IN; \$0 Copay OON (two per year) Includes exam, and cleaning X-Ray: \$0 Copay IN (one every year); \$0 Copay OON \$22 Copay IN; 25% Coinsurance OON Comprehensive maximum allowance of \$2000 Restorative Services, Endodontics, Extractions, Diagnostics, Periodontics: 50% Coinsurance IN. 50% Coinsurance OON. Periodontal cleanings \$0 Copay IN and OON. See EOC for benefit limits. \$15 Copay IN; 125% Coinsurance OON \$15 Copay IN; 12 per plan year); 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON \$22 Copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Partial Hospital: \$55 copay IN; 25% Coinsurance OON Outpatient Blood: \$0 Copay IN; 25% Coinsurance OON Profice of the second of t

Highmark Blue Cross Blue Shield of Western New York — **BlueCross BlueShield Freedom Valor**

Highmark Blue Shield of Northeastern New York



Highmark Blue Cross Blue Shield of Western New York — BlueCross BlueShield Freedom Valor Highmark Blue Shield of Northeastern New York — BlueShield Freedom Valor (Products and pricing by county)

	Freedom Valor PBO
Monthly Plan Premium	08
Part B Premium Giveback	058
Out-of-Pocket Maximum	Network; \$6,700; Catastrophic; \$10,000
PCP Office Visit	\$0 Copay IN; 50% Coinsurance OON
Specialist Office Visit	\$35 Copov IN: 50% Coinsurance OON
I ah and Diagnostic Tests (Dhye Office or Erecetandinal ah)	Splat Canav IV. 50% rains urance O.O.N. 4.8. diamone from IV. 50% Cains urance O.O.N.
Lab and Disappetic Tests (Outpatient Eacility)	SOLID CONTROL S. Criter transport D.O.N. S. A. Aliannostis test control IN-500. Control Contro
X-Rovs	245 Chord IV: 50% Chiral representation of the state of t
Radiation Therapy	20% Crinsurance IN: 50% Crinsurance OON
Advanced Imagina	S150 Copey N. 50% Cainsurance OON
Preventive/Screening	SOCONA IN 1992 CON
Output Division Cooch Thorass	St Conv. IN: CON.
Medicare Covered Actionstine	\$35 Chantilly 50% Chinestone OON
Output Octobra Thomas Thomas	CHECKER OF THE CONTRACTOR OF T
Outballen Occupational Interapy	STO CODE ON THE STORY OF THE ST
Outpatient Mental Health	SS Copay IN; 50% Coinsurance OON
Outpatient Substance Abuse	\$5 Copay IN; 50% Coinsurance OON
Outpatient Surgical (Includes Observation)	\$225 Copay IN; 50% Coinsurance OON
	\$325 Copay IN; 50% Coinsurance OON
Ambulance	\$200 Copav
Tomonortation	Not Conjust
101001001001001001001001001001001001001	Dalaco Ioni
Emergency Koom	S100 Copay
Urgent Care	\$55 Copay
Inpatient Hospital Stay (COVID-19 cost share waiver has been removed)	INN: \$290 per day for days 1—7, \$2,030 OOP Max per year; OON: 50% Coinsurance
Inpatient Psychiatry Stay	INN: \$260 per day for days 1-6. \$1.560 OOP Max per year: OON: 50% Coinsurance
Skilled Nursing Facility	INN: \$0 per day for days 1-20. \$203 per day for days 21-100. No yearly benefit period maximum. OON: 50% Coinsurance
Home Health	SO Concurrence OOM
	Copular in the copula
Diabetic Supplies and Services	
	Diabetic glucometer, test strip, and lancet brands dispensed via retail or mail order pharmacy are limited to Life Scan and Roche. Continuous glucose monitors, sensors and
	transmitters dispensed via retail or mail order pharmacy are limited to Abbott and Dexcom. All other desired brands will need to be obtained from a Durable Medicare Equipment
	(UME) provider (or an exception process); 50% coinsurance OUN
Durable Medical Equipment	INN: \$0 compression stockings, diabetic shoes/inserts; 20% all other items; OON: 50% Coinsurance
отс	\$25 quarterly allowance
Meal Benefit	\$0 copay, one meal per day for seven days upon discharge from an inpatient hospital, SNF or Inpatient Psychiatry stay. Must be activated within 30 days of discharge.
onpuo	\$0 Onduo Virtual Diabetes Program
Spring Health	\$0 behavioral health care program
CHE and CODD Management powered by Vida	Sonorana for CODD and connective heart failure to many and many M
Eithness Bonofit	Volumed in Collaboration of the control of the cont
Additional Telehealth Services	Services covered with annitirable Convolited for authoritent
Part Drive Chambel and All Other Dant D	10 NO Citation and Dark Development and DOV Citation and
rari b Drugs – Chemoinerapy and All Other Part b	VA-1939 Contistrative for Part blebatable aridgs and ZVA Contistrative CONT
Part B Drugs — Insulin	20% Coinsurance up to a maximum of a 555 copay for a one month supply of insulin IN 50% Coinsurance CON
Medicare Covered Vision (Office Visit)	\$35 (except \$0 for diabetic retinal eye exam); 50% coinsurance OON
Routine Vision (Office Visit)	\$25 Copay IN; 20% coinsurance OON; Benefit is carved out to Davis Vision
Routine Vision (Eyewear)	\$100 Allowance IN and OON Combined; Benefit is carved out to Davis Vision
Medicare Covered Hearing Exam	\$35 Copay IN; 50% Coinsurance OON
Routine Hearing Exam	\$45 Capay (one every year)
Routine Hearing (Hearing Aids)	Two hearing aids every year Tri Hearing Advanced - \$699 coppy Tri Hearing - \$999 coppy
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	Office, 50 Copdy III, 50 Copdy For I Mone every ward; SIC Croppy Try. X-Part: SIC Croppy III (Anne every ward; SIC Croppy DIA)
Medicare Covered Comprehensive Dental	SSE Convill, (SOS Chineterno ON
Dental Allowance — Preventive and/or Comprehensive	Combined maximum allowance of \$2000
Comprehensive Dental — Supplemental	Restorative Services Endodontics Prosthodontics Other Oral/Maxill forcia Suraery Extractions Non-Routine Services Diannostics Pariodontics 50% Coinsurance IN
	50% Coinsurance OON. Periodonial cleanings 80 Coppy IN and OON. See EOC for benefit limits.
Medicare Covered Chiropractic	\$15 Copay IN; 50% Coinsurance OON
Routine Chiropractic	S15 Copay IN (six per plan year); 50% Coinsurance OON
Medicare Covered Podiatry	\$35 Copay IN; 50% Coinsurance OON
Routine Podiatry	\$35 Copay IN; 50% Coinsurance OON (three visits)
Cardiac and Pulmonary Rehab and SET, Partial Hospital, Outpatient Blood	Cardiac Rehab: \$15 Copay IN; 50% Coinsurance OON; Partial Hospital: \$55 copay IN; 50% Coinsurance OON; Outpatient Blood: \$0 Copay IN; 50% Coinsurance OON
	Part D Drugs
Formulary	Not Covered
Deductible	Not Covered
Initial Coverage Period Limit: \$5,030. 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	Not Covered
Mail Order: Cost sharing is for up to 100-day supply for T1 and T2 and up to a 90-day	Not Covered
supply for 13 and 14, except Specialty fier (up to 31 days supply)	
Coverage Gap (Cost sharing is for up to 100-ady supply for 11 and 12 and up to 30-day supply))	Not Covered
Catastrophic OOP Threshold: \$8,000	NotCovered
IRA Benefits — T3 and T4 offered through ICP and Coverage Gap stages	Not Covered



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	Together Blue Medicare HMO	Community Blue Medicare HMO	
		Allegheny County		Medicare IIMO	Medicare IIMO	
AHN Allegheny General Hospital		, megnen, county	-	<u> </u>		
AHN Allegheny Valley Hospital	•	→	•	•	·	
AHN Brentwood Neighborhood Hospital	•	→	•	•	·	
AHN Forbes Hospital	•	→	•	•	•	
AHN Harmar Neighborhood Hospital	•	→	•	•	·	
AHN Jefferson Hospital	•	→	•	•	•	
AHN McCandless Neighborhood Hospital	•	→	•	•	<u> </u>	
AHN West Penn Hospital	•	→	•	•	<u> </u>	
AHN Wexford Hospital	•	•	•	•	<u> </u>	
Heritage Valley Kennedy	•	•	•		_	
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	_		-	<u> </u>		
		Blair County				
Conemaugh Nason Medical Center	_		•		_	
Penn Highlands Tyrone		•	•			
UPMC Altoona		·				
	UPMC Altoona Butler County					
Butler Memorial Health System		y	,			
UPMC Passavant Cranberry		`			· · · · · · · · · · · · · · · · · · ·	
UPMC Passavant Cranberry Cambria County						
Conemaugh Memorial Medical Center		v v	·			
Conemaugh Miners Medical Center	•	· · · · · · · · · · · · · · · · · · ·	•		· ·	
	•	Clarion County				
Clarion Hospital		v v	·			
Clarion Psychiatric Center	,	· · · · · · · · · · · · · · · · · · ·	•		, , , , , , , , , , , , , , , , , , ,	
	<u> </u>	Clearfield County	,			
Penn Highlands Clearfield		Clear Hela County	·			
Penn Highlands DuBois	•	· · · · · · · · · · · · · · · · · · ·	•			
r eminiginarias papols	,	<u> </u>	•		~	

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	Together Blue Medicare HMO	Community Blue Medicare HMO	
		Crawford County			•	
Meadville Medical Center	~	✓	~		~	
Titusville Area Hospital	·	✓	~		~	
Elk County						
Penn Highlands Elk	~	✓	~		~	
		Erie County				
AHN Saint Vincent Hospital	~	~	~	~	~	
Corry Memorial Hospital	~	✓	~		~	
		Erie County (cont'd)				
Millcreek Community Hospital	·	✓	~		~	
UPMC Hamot	·	✓	~			
		Fayette County				
Penn Highlands Connellsville	·	✓	~		~	
WVU Uniontown Hospital	*	✓	•		~	
		Greene County				
Washington Health System 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	v	✓	•	✓	~	
		McKean County				
Bradford Regional Medical Center	•	✓	•		•	
UPMC Kane	·	✓	•	•	•	
		Mercer County				
AHN Grove City	~	✓	•	•	~	
Edgewood Surgical Hospital	~	✓	•		~	
Sharon Regional Medical Center	~	✓	•		~	
UPMC Horizon	~	•	•	•	~	
UPMC Horizon — Shanango Campus	·	•	•	•	~	
		Potter County				
UPMC Charles Cole	~	•	•	•	~	
		Somerset County				
Chan Soon-Shiong Medical Center at Windber	,	•	•		,	
Conemaugh Meyersdale Medical Center	·	✓	~		·	
UPMC Somerset	·	✓	~	~	~	

WPA, cont.

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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	Together Blue Medicare HMO	Community Blue Medicare HMO
		Venango County			
UPMC Northwest	~	→	~	~	~
		Warren County			
Warren General Hospital	~	✓	~		~
		Washington County			
Advanced Surgical Hospital	~	✓	~		~
AHN Canonsburg Hospital	~	~	~	~	~
Penn Highlands Mon Valley Hospital	~	~	~		~
Washington Hospital	~	✓	~		~
		Westmoreland County			
AHN Hempfield Neighborhood Hospital	·	✓	~	~	~
Excela Health Frick Hospital	~	✓	~		~
Excela Health Latrobe Hospital	~	✓	~		~
Excela Health Westmoreland Hospital	~	✓	~		~

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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	Community Blue Medicare PPO
	Adams Coun	ty		
WellSpan Gettysburg Hospital	~	✓	~	~
	Berks Count	у		
Penn State Health St. Joseph Medical Center	~	✓	~	~
Reading Hospital	~		~	~
Surgical Institute of Reading	~		~	~
	Bradford Cou	nty		
Guthrie Robert Packer Hospital	~	~	~	~
Guthrie Robert Packer Hospital — Towanda Campus	~	~	~	~
Guthrie Troy Community Hospital	~	~	~	~
	Carbon Coun	ty		
Lehigh Valley Hospital — Carbon	~	✓	~	→
St. Luke's Hospital — Carbon	~	✓	~	✓
St. Luke's Hospital — Lehighton Campus	~		~	✓
	Centre Coun	ty		
Mount Nittany Medical Center	~	~	~	~
	Clinton Coun	ty		
Bucktail Medical Center	~		~	✓
UPMC Lock Haven Hospital	~		~	~
	Columbia Cou	nty		
Geisinger Bloomsburg Hospital	→		✓	~
	Cumberland Co	unty		
Penn State Health Hampden Medical Center	•	✓	•	✓
Penn State Health Holy Spirit Hospital	•	✓	•	✓
UPMC Pinnacle Carlisle	•		•	✓
UPMC Pinnacle West Shore Campus	~	✓	→	✓
	Dauphin Cour	nty		
Penn State Health Milton S. Hershey Medical Center	~	~	~	~
UPMC Pinnacle Community Osteopathic	~	~	~	~
UPMC Pinnacle Harrisburg Campus	~	~	~	~
	Franklin Cour	ity		
WellSpan Chambersburg Hospital	~	~	~	~
WellSpan Waynesboro Hospital	~	~	~	~
	Fulton Count	у		
Fulton County Medical Center	~		~	~
	Lackawanna Co	unty		
Geisinger Community Medical Center	~		~	~
Lehigh Valley Hospital — Dickson City	~	~	•	~
Moses Taylor Hospital	~	~	•	~
Regional Hospital of Scranton	✓	✓	~	✓

CPA and NEPA, cont.

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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	Community Blue Medicare PPO		
Lancaster County						
Lancaster General Hospital	~	~	~	~		
Penn State Health Lancaster Medical Center	·	~	~	~		
UPMC Pinnacle Lititz	~		~	~		
WellSpan Ephrata Community Hospital	✓	~	~	~		
	Lebanon Cour	nty				
WellSpan Good Samaritan Hospital	•	~	~	~		
	Lehigh Coun	ty				
Lehigh Valley Coordinated Health Hospital of Allentown	•	~	~	~		
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 Cour	nty	'			
Lehigh Valley Hospital — Hazleton	•	~	~	~		
Wilkes-Barre General Hospital	~	~	~	~		
	Lycoming Cou	nty				
Geisinger Jersey Shore Hospital	•		~	~		
Geisinger Medical Center Muncy	~		~	~		
UPMC Muncy Valley Hospital	~	~	~	~		
UPMC Susquehanna Divine Providence Hospital	~	~	~	~		
UPMC Williamsport Hospital	~	~	~	~		
	Mifflin Coun	ty				
Geisinger Lewistown Hospital	~		~	~		
	Montour Cour	nty	1			
Geisinger Medical Center			~			
	Monroe Cour	nty	<u>'</u>			
Lehigh Valley Hospital — Pocono	~	~	~	~		
St. Luke's Hospital — Monroe Campus	~		~	~		
	Northampton Co	ounty	•			
Lehigh Valley Coordinated Health Bethlehem Hospital	~	~	~	~		
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	•		<u> </u>	<u> </u>		

CPA and NEPA, cont.

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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	Community Blue Medicare PPO		
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 Co	unty				
Barnes-Kasson County Hospital	·		~	~		
Endless Mountain Health Systems	•	~	~	~		
	Tioga County	1				
UPMC Soldiers and Sailors Hospital	•	→	~	~		
	Union County	/				
Evangelical Community Hospital	~		~	~		
Wayne County						
Wayne Memorial Hospital	•	→	·	~		
	Wyoming Cour	nty				
Tyler Memorial Hospital	·	→	~	~		
	York County					
OSS Health Orthopaedic Hospital	·		~	~		
UPMC Pinnacle Hanover	•		~	~		
UPMC Pinnacle Memorial	·		~	~		
WellSpan Surgery and Rehabilitation Hospital	~	✓	~	~		
WellSpan York Hospital	·	✓	~	~		



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Freedom Blue PPO In—Network Hospitals

Facility Name	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	Brooke	
Cabell Huntington Hospital		
River Park Hospital	Cabell	
St. Mary's Medical Center		
Montgomery General Hospital		
CAMC — Plateau Medical Center	Fayette	
Grant Memorial Hospital	Grant	
CAMC — Greenbrier Valley Medical Center	Greenbrier	
Valley Health — Hampshire Memorial Hospital	Hampshire	
WVU Medicine — United Hospital Center	Harrison	
WVU Medicine — Jackson General Hospital	al Hospital Jackson	
WVU Medicine — Jefferson Medical Center	Jefferson	
Charleston Area Medical Center		
Charleston Surgical Hospital		
Select Specialty Hospital — Charleston	Kanawha	
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		
WVU Medicine – Fairmont Medical Center	Marion	

Facility Name	Freedom Blue PPO	
	County	
WVU Medicine — Reynolds Memorial Hospital	Marshall	
Pleasant Valley Hospital	Mason	
Welch Community Hospital	McDowell	
WVU Medicine — Princeton Community Hospital	Mercer	
WVU Medicine — Potomac Valley Hospital	Mineral	
Mon Health Medical Center		
WVU Medicine — Chestnut Ridge Center		
WVU Medicine — Children's Hospital	Monongalia	
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	21.	
WVU Medicine — Wheeling Hospital	Ohio	
Pocahontas Memorial Hospital	Pocahontas	
Mon Health Preston Memorial Hospital	Preston	
CAMC — Teays Valley Hospital	Putnam	
Beckley ARH Hospital	B 1 · · ·	
Raleigh General Hospital	Raleigh	
Davis Medical Center	Randolph	
Roane General Hospital	Roane	
Summers County ARH Hospital	Summers	
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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Freedom Blue PPO In-Network Hospitals

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

Northeastern New York

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In-Network Hospitals

Facility Name	County	
Albany Medical Center Hospital		
Albany Medical Center Hospital Rehab		
Albany Medical Center South Clinical Campus	Albany	
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	M	
St Mary's Hospital Memorial Campus	Montgomery	
Samaritan Hospital	Rensselaer	
Saratoga Hospital	Saratoga	
Bellevue Woman's Care Center of Ellis Hospital		
Ellis Hospital	Schenectady	
Sunnyview Hospital		
Cobleskill Regional Hospital	Schoharie	
HealthAlliance Mary's Avenue Campus	Ulster	
Glens Falls Hospital	Warren	

Western New York

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In-Network Hospitals

Facilty Name	County	
Cuba Memorial Hospital	A.II	
Jones Memorial Hospital	Allegany	
Brooks Memorial Hospital		
Lake Shore Hospital Inc.		
Olean General Hospital	Cattaraugus	
UPMC Chautauqua at WCA		
Westfield Memorial Hospital		
AHN Saint Vincent Hospital		
Bertrand Chaffee Hospital		
Bry Lin Hospital		
Buffalo General Hospital		
Encompass Health Rehabilitation Hospital of Erie		
Erie County Medical Center		
John R Oishei Children's Hospital		
Kaleida Heath	Erie	
Kenmore Mercy Hospital		
Mercy Hospital of Buffalo		
Millard Fillmore Suburban Hospital		
Roswell Park Cancer Institute		
Sisters of Charity Hospital		
Sisters of Charity Hospital — St. Joseph Campus		
UPMC Hamot Medical Center		
United Memorial Medical Center	Genesee	
Nicholas H. Noyes Memorial Hospital	Livingston	
Bradford Regional Medical Center	Mckean	
Highland Hospital		
Rochester General Hospital		
Strong Memorial Hospital	Monroe	
Unity Hospital of Rochester		
Unity Hospital of Rochester — Buffalo Road		
DeGraff Memorial Hospital		
Eastern Niagara Hospital — Lockport		
Eastern Niagara Hospital — Newfane	Niagara	
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	

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SECTION III: MEDICARE ADVANTAGE

Additional Resources

Part B and D IRMAA

What is the Part B and Part D Income Related Monthly Adjusted Amount (IRMAA)?

If your client or prospective client has a higher income, the law requires an adjustment to their monthly premiums for Medicare Part B (medical insurance) and Medicare Part D (prescription drug coverage). This adjustment is known as the Income Related Monthly Adjustment Amount (IRMAA). IRMAA is paid directly to Medicare, it is not part of the plan premium. Your client will be notified by Social Security if IRMAA is applicable. The following table is the most current information available as of the date of publication of this guide. Please note that the standard premium for 2023 is \$164.90.

File individual tax return*	File joint tax return*	File married and separate tax return*	Part B Monthly Premium Increase	Part D Monthly Premium Increase
\$97,000 or less	\$194,000 or less	\$97,000 or less	\$0	Plan premium
Above \$97,000 up to \$123,000	Above \$194,000 up to \$246,000	Not Applicable	\$65.90	\$12.20
Above \$123,000 up to \$153,000	Above \$246,000 up to \$306,000	Not Applicable	\$164.80	\$31.50
Above \$153,000 up to \$183,000	Above \$306,000 up to \$366,000	Not Applicable	\$263.70	\$50.70
Above \$183,000 up to \$500,000	Above \$366,000 up to \$750,000	Above \$97,000 up to \$403,000	\$362.60	\$70
\$500,000 and above	\$750,000 and above	\$403,000 and above	\$395.60	\$76.40

^{*}Based on 2021 filing for 2023 calendar year.

Medicare Advantage and Part D Election Periods

Initial Election Period (IEP) is the period during which an individual may make an initial election to enroll in an MA plan.

Annual Election Period (AEP) is the period when an individual may enroll or disenroll from an MA plan.

Open Enrollment Period (OEP) is a time frame that allows an individual enrolled in a Medicare Advantage plan* a one-time opportunity to:

- Switch to a different Medicare Advantage plan.
- Drop their Medicare Advantage plan and return to Original Medicare, Part A and Part B.
- Sign up for a stand-alone Medicare Part D Prescription Drug plan (if they return to Original Medicare).

Special Election Period (SEP) is a time frame that allows some individuals to enroll in an MA plan outside of the IEP and AEP if they meet certain requirements. A few examples are people who are eligible for extra help in paying for their Medicare prescription, such as if they qualify for Low Income Subsidy (LIS) or Programs of All-Inclusive Care for the Elderly (PACE), or people who have lost their employer group coverage or relocated outside the plan's service area.

	Part C	Part D	Plans Availabl	e	
	(Medicare Advantage plans)	(Prescription Drug plans)	MA/MA-PD	PDP	Medigap
IEP	Once per lifetime	Starts 3 months before and ends 3 months after month of eligibility — total 7 months	X	X	X
AEP	Oct. 15 to Dec. 7	Oct. 15 to Dec. 7	X	X	X
OEP*	Jan. 1 to March 31		X	X	X
SEP	All year	All year	Х	X	X
5-Star SEP					

^{*}Individuals enrolled in Original Medicare, a cost plan, or other plan types are not eligible to use OEP to enroll in an MA plan. Individuals enrolled in a Part D only plan are not eligible to make changes during OEP.

PACE and PACENET

What is PACE/PACENET coverage?

The Pharmaceutical Assistance Contract for the Elderly (PACE) program is a lottery-funded program that provides prescription drug coverage to Pennsylvania residents, ages 65 and older, who meet the program's income requirements:

	Single Income Limit	Married Income Limit	Copay Generic	Copay Single-Source Brand
PACE	\$14,500	\$17,700	\$6	\$9
PACENET	\$14,500 – \$33,500	\$17,700 – \$41,500	\$8	\$15

PACE/PACENET FAQs

Q: If I am enrolled in a Highmark Part D plan, will I still use my PACE or PACENET card?

Yes, show both cards at the pharmacy. This will let your pharmacist know to bill Highmark first and bill PACE or PACENET second. It will also let your pharmacist know that you are entitled to all of the drugs that are available under PACE and PACENET.

Q: Will my copayments be higher with PACE/PACENET and Highmark Part D plan?

No, not for medications that are covered by PACE/PACENET. If your Highmark plan charges higher copayments than you were paying under PACE/PACENET, the program will pay the difference if the pharmacy has the capability to bill more than one payer for a prescription claim. If you are taking medications that are not covered by PACE/PACENET, you will pay the Highmark plan's copay for those drugs. If you run into any confusion at the pharmacy, call the program's toll-free number at **800-225-7223** while you're still at the pharmacy.

Q: What happens if my Highmark plan charges lower copayments than PACE/PACENET?

You will pay the lower copayments when the Part D plan pays for medication.

Q: Many Highmark Part D plans stop their coverage after you reach a certain dollar limit. This is referred to as the "donut hole" or "coverage gap." How will this work if I have PACE/PACENET?

You will not experience a "donut hole" or period of time when you have no prescription drug coverage. Instead, the PACE/PACENET program will fill in the gaps for covered medications, so that you can continue to get your prescriptions by only paying the PACE/PACENET copays.

Q: What happens if my Highmark Part D plan doesn't cover all of the drugs that PACE/PACENET covers?

If your Part D plan has a restrictive drug formulary, PACE/PACENET will cover your prescription medications or work directly with the plan to process a prior authorization on your behalf so the drugs will be covered by your Part D plan.

Q: Can I go to any pharmacy I choose if I am in PACE and Medicare Part D?

No. You must use the pharmacies that are in your Highmark Part D plan's network. If you decide to change pharmacies, check with your new pharmacy to make sure they participate in your Highmark Part D plan and PACE.

Q: If my Part D plan offers a mail-order service, can I use it?

Yes. However, the mail order pharmacy must participate with the PACE Program in order for the program to help pay for your extra copayments. Please have your doctors verify if the mail order pharmacy is in the PACE network prior to submitting prescriptions for processing. Also, when you receive a three-month supply of your drug(s) by mail, you will pay up to three PACE/PACENET copayments at once. For example, a PACE cardholder would pay up to \$18 for a 90-day supply of generic medications.

New York EPIC Program

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program for seniors administered by the Department of Health. It helps more than 325,000 income-eligible seniors aged 65 and older to supplement their out-of-pocket Medicare Part D drug plan costs. Seniors can apply for EPIC at any time of the year and must be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage.

EPIC provides secondary coverage for Medicare Part D and EPIC-covered drugs purchased after any Medicare Part D deductible is met. EPIC also covers approved Part D-excluded drugs once a member is enrolled in Part D.

To join EPIC, a senior must:

- Be a New York State resident age 65 or older.
- Have an annual income below \$75,000 if single or \$100,000 if married.
- Be enrolled or eligible to be enrolled in a Medicare Part D plan (no exceptions), and not be receiving full Medicaid benefits.

Note: You can join EPIC at any time during the year. Once enrolled, you will receive a 'Special Enrollment Period' to join a Medicare Part D drug plan. You are not eligible to receive EPIC benefits until you are enrolled in a Part D drug plan.

Seniors who are not eligible to join a Medicare Part D drug plan cannot join EPIC (e.g., seniors with a union/retiree drug subsidy program that is not a Part D plan, seniors without Medicare Part A or Medicare Part B).

Seniors with Medicare Advantage (HMO) health insurance can only join EPIC if they have Part D drug coverage with their HMO.

Residency

To enroll in EPIC, you must be a resident of New York State. This means that your permanent home (not a summer or winter home) is located in New York State. It also means you live in the State on a regular, ongoing basis, and your New York State address is listed as your home address on official and legal documents. You need to notify EPIC whenever you change your address.

Income

For purposes of your EPIC enrollment, household gross income is the previous year's total annual income of the senior or married spouses. It includes, but is not limited to:

- Federal adjusted gross household income as reported on your income tax return.
- Social Security payments (less Medicare premiums).
- · Railroad retirement benefits.
- The taxable amount of IRA distributions and retirement annuities.
- Support money, including foster care support payments.
- Supplemental Security income.
- Tax-exempt interest.
- Worker's compensation.
- Gross amount of loss-of-time insurance.
- Cash public assistance and relief, other than medical assistance for the needy.
- Non-taxable strike benefits.
- Veterans' disability pensions.
- Lottery winnings.

It does not include:

- Food stamps.
- Medicare premiums.
- · Medicaid.
- Scholarships.
- Grants.
- Surplus food.
- Payments made to veterans under the federal Veterans' Dioxin and Radiation Exposure Compensations Standards Act (Agent Orange).
- Payments made to individuals because of their status as victims of Nazi persecution.

Low Income Subsidy (LIS)

The Low Income Subsidy (LIS) helps people with Medicare pay for prescription drugs, and lowers the costs of Medicare prescription drug coverage.

The resource limits used to determine eligibility for the LIS are as follows:

LIS Level	Marital Status	2023 LIS Resource Limit	
Full Subsidy LIS	Single	\$10,590	
	Married	\$16,630	
All Other LIS	Single	\$16,660	
	Married	\$33,240	

The maximum LIS beneficiary cost-sharing table is as follows:

Low-Income Subsidy Category	Deductible	Copayment up to Out-of-Pocket Threshold*	Copayment Above Out–of–Pocket Threshold*
Institutionalized Full–Benefit Dual Eligible; or Beneficiaries Receiving Home and Community–Based Services	\$0	\$0	\$0
Full-Benefit Dual Eligible ≤ 100% Federal Poverty Level (FPL)	\$0	\$1.45 generic, \$4.30 brand	\$0
Full-Benefit Dual Eligible > 100% FPL; or Medicare Saving Program Participant; or SSI (but not Medicaid) Recipient; or Applicant < 135% FPL	\$0	\$4.15 generic, \$10.35 brand	\$0
Applicant < 135% FPL	\$0	\$4.15 generic, \$10.35 brand	\$0
Applicant < 150% FPL	\$104	15%	\$4.15 generic, \$10.35 brand

Frequently Asked Questions

Q: What is the difference between the Freedom Blue and Complete Blue networks?

The **Complete Blue PPO** network offers broad access including INN to all western Pennsylvania Hospitals (including UPMC). Additionally, it provides:

- Highest quality, narrow network supplemental providers (SNF, DME, etc.).
- INN access to all BCBS MA providers across the country.
- Emergent and Urgent Care covered worldwide.

The **Freedom Blue PPO** network (western Pennsylvania) offers INN Access to all western Pennsylvania Hospitals. Additionally, it provides:

- Broad network of supplemental providers (SNF, DME, etc.) throughout western Pennsylvania.
- POS access to OON providers.
- Emergent and Urgent Care covered worldwide.

Q: How do I locate a provider within the Blue Card network?

For PPO members visiting a county or state outside of their current plan coverage area, they can locate providers by following these steps:

- 1. Visit provider.bcbs.com.
- 2. Enter a Zip code.
- 3. Select Browse a List of Plans.
- 4. Choose **Medicare Advantage PPO** and scroll down to choose the appropriate Highmark home plan.

Q: What is the claim submission process when utilizing a provider through the BlueCard network?

Participating providers should submit claims to their local Blue Plan.

Q: How am I billed for Emergency Care Worldwide?

When outside of the United States members should expect to pay upfront, however they can then submit an itemized receipt for reimbursement, less their Emergency Care copay.

Q: What happens to my total drug spend if I switch plans throughout the year?

Their drug spend will only reset Jan. 1 of each year. It does not reset when changing plans.

Q: How can I obtain my diabetic testing supplies?

Lifescan and Abbott brand testing supplies are available at pharmacies and DME suppliers. Other brands can either be obtained at a DME supplier or with a physician authorization at pharmacies.

Q: How is Transportation covered with Community Blue Medicare?

The benefit will allow for a one-way trip to the home for continued acute care after discharge from an emergency room and any additional trips to a physician related to the continued acute home care. Arrangements for the trip will be made through the servicing provider.

Q: How is Transportation covered with Freedom Blue and Security Blue Medicare plans?

There is a \$0 In-Network copay per one-way trip and provides a benefit for up to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits, appointments for dental, vision, hearing, and behavioral health services, and visits to pharmacies to pick up prescription drugs within a 50-mile limit. The destination must always be plan-approved.

Q: Where can I go to pay the lowest amount for lab work?

To a participating freestanding lab such as Quest Diagnostics and Labcorp. Please check the provider search tool to verify available freestanding labs. Labs at a hospital or affiliated with a hospital will not process with the lowest cost share.

Q: How do I utilize the OTC benefit? Am I automatically sent a catalog?

You may redeem your OTC benefits by visiting the online store at **shophighmarkotc.com**. Physical catalogs are available on request from Member Service.

Q: Does an unused OTC benefit amount carry over to the next quarter?

No, it does not. OTC benefits must be used within the calendar quarter, or they will be forfeited. Conversely, any amount spent above the benefit allowance per quarter will be the responsibility of the member.

Q: Is shipping covered with my OTC benefit?

Shipping is free for the first order per quarter. All subsequent orders will incur a shipping charge at the member's expense.

Q: How can I reach TruHearing to utilize benefits?

Contact TruHearing directly at **855-544-7171** (or 800-334-1807, TTY: 711) to locate a provider and schedule an appointment.

Q: Where can I find a list of participating vision providers?

Optometrists for routine vision can be found by visiting **davisvision.com**.

- 5. Select **Find an eye care professional** from the banner at the top of the homepage.
- 6. From there you will be able to search by location and/or the provider's name or business name.

Q: Where can I find a list of participating dental providers?

Routine dental providers can be found by visiting **unitedconcordia.com**.

- 1. Locate the three lines in the top right corner, select **Find a Dentist**.
- 2. Choose your location.
- 3. Select your network: National Medicare Advantage Dental (This is the same for all of our MAPD plans that include dental, as well as the Whole Health Balance option offered to Medigap members).

Q: Why am I still receiving invoices despite signing up for Electronic Funds Transfer (EFT)?

EFT takes approximately 45-60 days to be set up. Timing can be impacted by queue volume and response time from the member's bank. In the meantime, you will need to continue paying invoices until they receive notice that EFT is starting deductions.

Q: A client would like me to be their Agent of Record (AOR). How do I request this change?

A change cannot be requested. If the agent submits a plan change, the AOR change will go through. Duplicate applications submitted for the active plan will not process as an AOR change.

Tips for Using the Online Provider Search Tool

Q: How do I locate the provider search tool?

medicare.highmark.com

At the bottom of the homepage, you will find useful links such as **Find a Provider** and **Find a Dentist**. The dental link will automatically link you to the National Medicare Advantage dental search. Please note, the vision link is for a medical specialist (ophthalmologist). If you are looking for a routine vision provider, please see **davisvision.com**.

Q: Why am I only finding one or a few of the providers from a practice and not the actual provider my client sees?

If you find the practice itself or other providers at that location, you can consider all providers at the practice/location as participating.

Q: How do I find providers outside of the Highmark sales region?

provider.bcbs.com

Choose a location and a plan. From there, you will be asked for the alpha prefix. To bypass, select **Browse a list of plans**. For PA, you can use PA Highmark Blue Shield or PA Highmark Blue Cross Blue Shield. For WV, use WV Highmark Blue Cross Blue Shield. From there, you can search for providers available through our Travel Program.

Q: Where do I find providers from the five Philadelphia counties?

Use **provider.bcbs.com**. These counties are considered out of the area.

Q: Why am I having trouble locating routine vision and dental providers?

An optometrist for routine vision can be found at **davisvision.com**. Routine dental providers can be found at **unitedconcordia.com**.

Q: What is the dental network?

All plans that include dental coverage (Whole Health Balance as well) use the National Medicare Advantage network through United Concordia.

Medical Underwriting Guidelines

Medigap Blue — Pennsylvania Updated Underwriting Guidelines

Health questions to determine eligibility — Pennsylvania

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions, if answered "yes," will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia, lymphoma, melanoma

- Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), or hemophilia
- Bone marrow or other organ transplant
- ALS (Lou Gehrig's disease), multiple sclerosis (MS), Parkinson's, systemic lupus erythematosus (SLE), Alzheimer's, or dementia
- AIDS, AIDS-related complex (ARC), or tested positive for HIV
- Chronic renal disease such as ESRD
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

Health questions to determine eligibility — Pennsylvania (cont.)

The following questions help determine rate.

If answer is "no" to the following questions, the application is approved at the preferred rate, unless the BMI is 40 or greater. If BMI is 40 or greater, the application is approved at the standard rate.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?
 - Heart conditions
 - » Heart rhythm disorders
 - Lung conditions
 - » Chronic obstructive pulmonary disease (COPD)
 - » Emphysema
 - Liver conditions
 - » Cirrhosis of the liver
 - » Hepatitis C
 - Diabetes
 - » Type I or Type II
 - Eye conditions
 - » Macular degeneration
- Gastrointestinal conditions
 - » Chronic pancreatitis
 - » Esophageal varices
 - » Ulcerative colitis
 - Musculoskeletal conditions
 - » Amputation due to disease
 - » Rheumatoid arthritis
 - » Spinal stenosis
 - » Degenerative disk or herniated disk
 - » Osteoporosis

- Psychological/mental conditions
 - » Bipolar or manic depressive
 - » Schizophrenia
- Substance abuse
 - » Alcohol abuse or alcoholism
 - » Drug abuse or use of illegal drugs
- Within the past two years, have you ever:
 - Been hospitalized or had inpatient surgery?
 - Smoked cigarettes or used any tobacco product?

If a "yes" answer is provided for any of these questions, the application is approved at the standard rate.

If a "yes" answer is provided for the tobacco question and there is one or more "yes" answers in these questions, the application is denied.

If applicant answers "no" to these questions, with exception of "yes" answer to the tobacco question and the applicant's BMI is 40 or greater, the application is denied.

If all answers are "no" and the tobacco question is answered "yes" and the applicant's BMI is less than 40, the application is approved at the standard rate.

Medigap Blue — West Virginia Updated Underwriting Guidelines

Health questions to determine eligibility — West Virginia

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions help determine rate.

The following questions, if answered "yes," will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia or lymphoma, melanoma
 - Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), hemophilia, or heart rhythm disorders
 - Diabetes
 - Chronic obstructive pulmonary disease (COPD), emphysema
 - Bone marrow or other organ transplant
 - ALS (Lou Gehrig's disease), multiple sclerosis (MS), Parkinson's, systemic lupus erythematosus (SLE), Alzheimer's, or dementia
 - AIDS, AIDS-related complex (ARC), or tested

- positive for HIV
- Hepatitis C
- Chronic pancreatitis, esophageal varices, or ulcerative colitis
- Chronic renal disease such as ESRD
- Bipolar, manic depressive, schizophrenia, or psychological illness requiring hospitalization
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

Responses to the following questions will be collected, but will not affect the outcome of the review.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?
 - Musculoskeletal conditions
 - » Amputation due to disease
 - » Rheumatoid arthritis
 - » Spinal stenosis
 - » Degenerative disk or herniated disk
 - » Osteoporosis
 - Liver conditions
 - » Cirrhosis of the liver
 - Eye conditions
 - » Mascular degeneration
- Within the past two years, have you ever:
 - Been hospitalized or had inpatient surgery?
 - Smoked cigarettes or used any tobacco product?

If the applicant's BMI is greater than 40, the application is denied.

Medigap Blue — Delaware Underwriting Guidelines

Health questions to determine eligibility — Delaware

Prior to approving an application for enrollment, Highmark reserves the right to review previous and current applications for coverage as well as claims history.

The following questions, if answered "yes," will result in a member not being eligible for a Medigap Blue plan.

- Were you enrolled in Medicare prior to age 65 due to a disability?
- Are you now or have you been advised in the next year to be any of the following?
 - Admitted as an inpatient to a hospital
 - Confined to a nursing facility for other than short-term rehabilitation
 - Paralyzed, bedridden, or confined to a wheelchair
 - Receiving dialysis
- Within the past two years, have you been diagnosed or treated (including prescription drugs) for any of the following conditions? Do not include any genetic information, such as family medical history or any information related to genetic testing, services, or counseling.
 - Cancer (other than skin cancer), leukemia, lymphoma, melanoma
 - Heart, coronary, or carotid artery disease (not including high blood pressure), heart attack, aneurysm, congestive heart failure or any other type of heart failure, enlarged heart, stroke, transient ischemic attacks (TIA), or hemophilia
 - Diabetes (using insulin)
 - Bone marrow or other organ transplant
 - ALS (Lou Gehrig's disease), multiple sclerosis (MS), Parkinson's, systemic lupus erythematosus (SLE), Alzheimer's, or dementia
 - AIDS, AIDS-related complex (ARC), or tested positive for HIV

- Chronic renal disease such as ESRD
- Cirrhosis of the liver, hepatitis C
- Chronic obstructive pulmonary disease (COPD), emphysema
- Alcohol abuse or alcoholism, drug abuse or use of illegal drug
- Bipolar or manic depressive, schizophrenia, psychological illness requiring hospitalization
- BMI greater than 40
- Have you been advised to have a joint replacement in the next year, or have you received a joint replacement within the past six months?

The following determines rate.

 If the answer to tobacco usage in the past 12 months is "yes," a 25% surcharge will be added to the premium.

Responses to the following questions will be collected, but will not affect the outcome of the review.

- Have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?
 - Heart conditions
 - Heart rhythm disorders
 - Musculoskeletal conditions
 - Amputation due to disease
 - Rheumatoid arthritis
 - Spinal stenosis

- Degenerative disc or herniated disc
- Osteoperosis
- Gastrointestinal conditions
- Chronic pancreatitis
- Esophageal varices
- Ulcerative colitis

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C)

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Supplement Plans (Medigap)

Medicare Supplement (Medigap) Plan — A Medicare Supplement Insurance (Medigap) policy, sold by private companies, can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, impact your current or future enrollment status or enroll you in a Medicare plan.

Beneficiary or authorized representative signature and signature date

gnature: Date:		
you are the authorized representative, please sign above a	nd print below:	
epresentative's name:		
our relationship to the beneficiary:		
To be completed by Agent		
Agent name:	Agent phone:	
Beneficiary name: Beneficiary phone:		
Initial method of contact: (Indicate here if beneficiary was a walk-in)		
Agent signature:		
Plan(s) represented during the meeting:		
Date appointment completed:		
[Plan use only:]		
*Scope of Appointment documentation is subject to CMS record retention of the form was signed by the beneficiary at time of appointment, the Agent prior to meeting on the lines provided below:	•	

Agent Sales Checklist

Identify yourself as a Highmark licensed sales agent and have your name badge displayed.	Discuss the differences between MA and Medicare Supplement plans.
Confirm the Scope of Appointment was completed prior to the start	Ensure the beneficiary(s) understood each plan(s) network and how they work.
of the meeting. Explain that in order to enroll in a	Explain how to locate a provider using the provider directory and/or provider website.
Medicare Advantage plan, members must be enrolled in Medicare and continue to pay Part B premium.	Explain how to check if drugs are covered in the formulary.
Describe Original Medicare and how it works when enrolled in a Medicare Advantage plan.	Review the Star Rating for all applicable plans.
Accurately describe the plans' deductibles, copays, coinsurance, OOP max.	Describe the different enrollment periods including AEP, MAPD, and possible SEPs.
Accurately describe the copays and deductibles for drugs under Part D.	Avoid making absolute statements.
Fully explain the cost of prescriptions during the coverage gap and	Avoid scare tactics.
catastrophic coverage period.	Avoid cross-selling of non-health products.
Explain that certain prescription drugs have restrictions such as prior authorizations or quantity limits.	Avoid using unapproved

SECTION IV

Highmark Wholecare

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Introduction

Highmark Wholecare Medicare Assured Diamond and Medicare Assured Ruby are specialized Medicare Advantage Plans (Medicare "Special Needs Plans"), which means the benefits are designed for people with special health care needs who have Medicare and are also entitled to assistance from Medicaid. Like all Medicare Advantage Plans, these Medicare Special Needs Plans are approved by Medicare and have contracts with the Pennsylvania Medicaid program to coordinate Medicaid benefits.

What is a Dual Eligible Special Needs Plan?

Members who are eligible for both Medicare and Medicaid (Medical Assistance from the State), can join a Dual Eligible Special Needs Plan (DSNP). DSNPs are approved by Medicare but are run by private companies.

Benefits of a DSNP:

- Members get hospital, medical, and prescription drug coverage through one plan.
- Members have a large network of providers to choose from.
- All medically necessary and preventive services offered under parts A and B are covered, in addition to prescription drug coverage under Part D.
- Many plans offer value added benefits, including hearing, dental, vision, transportation, healthy food cards, and more.

D-SNP Enrollment Periods

Initial Enrollment Period (IEP)

This is a seven-month period that starts three months before the month containing the member's 65th birthday, and continues for three months after.

Special Enrollment Period (SEP)

A member can change plans quarterly except for in the last quarter because of AEP. They can change plans if they're moving out of their current plan's service area, losing creditable group health insurance due to employment ending, or being released from jail. Some of the events that can qualify a member to enroll in a DSNP during this period include:

- Beneficiaries are given Q1, Q2, and Q3 SEP to change plans.
- Nursing home residency. Whether they're moving in, moving out, or are currently living in a nursing home, they can enroll in a Special Needs Plan for the first time, switch plans, or opt out of their current plan.
- Qualifying for Medicaid. If they already have Medicaid benefits or become eligible, they can enroll in a Special Needs Plan at any time. Moving outside the service area. If they move outside the service area covered by their current Special Needs Plan and they want to switch to another plan, they can do it during the SEP. If they do not enroll in a different DSNP, they are automatically returned to coverage through Original Medicare.
- Their current DSNP leaves Medicare. If this happens, they can sign up for a different DSNP.

Annual Enrollment Period (AEP)

Oct 15. – Dec. 7 — Members can switch plans as many times as they want during AEP. They have until Dec. 7 by 11:59 p.m. to make a final decision.

Enrollment Processes

Cavulus

Cavulus is a CRM (Customer Relationship Management) software used to store contacts, sales opportunities, and upcoming seminars. It helps to prioritize tasks, schedule plans, and optimize member experience. Everything is automatically uploaded in the program, including member names, addresses, and any other details required for registration. You can easily contact members and access their background information to understand their plan needs.

How to use Cavulus

- Sign in to your workspace with your Username and Password.
- Select Broker Enrollment.
- In quick forms, you can either choose
 New Enrollment or Edit Current Active.
 - Select product type: **Diamond** or **Ruby**
 - For election type, either enter Unknown or pick from the types listed
 - Choose the Effective Date
 - Choose the App Recs Date
 - Choose the Application Type
 - Type in Medicare Identifier if applicable
 - Fill in Date of birth
 - Upload any applicable files (Ex: Scope of Appointment (SOA))
 - Confirm Enrollment





Checklist for enrollment

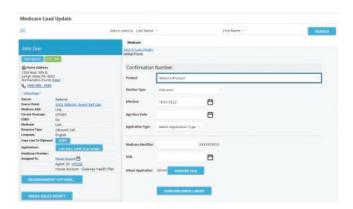
Information you'll need to enroll a member:

- Name
- Address
- Date of Birth
- Social Security Number
- Medicaid and Medicare numbers
- List of current doctors and prescriptions

How to check eligibility

To check for eligibility of a prospective member or if you need a SOA, you can contact Agent Support over the phone at **888-871-0417** or by email at **agentspecialist@highmarkwholecare.com**.

- Make sure you have a PTC (Permission to Contact)/ Scope of Appointment.
- Have the member's name, address, and date of birth handy. If you're calling Agent Support, you should also have their social security number (SSN) and Medicare Beneficiary Number (MBI), if possible.



Products Overview

Highmark Wholecare offers two DSNP plans:

Medicare Assured [™] Diamond	Medicare Assured Ruby
Live in service area	Live in service area
Entitled to Medicare Part A	Entitled to Medicare Part A
Enrolled in Medicare Part B	Enrolled in Medicare Part B
Full Medicaid: QMB, QMB+, SLMB+, and FBDE	Partial Medicaid: SLMB, and QI

To be eligible for the Diamond plan, you must have Medicare Parts A and B and Medical Assistance (FBDE, QMB+, SLMB+, or QMB) and you must live in our service area. To be eligible for the Ruby plan, you must have Medicare Parts A and B and Medical Assistance (SLMB or QI) and you must live in our service area.

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 Plus)	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 Plus)	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.	

Value-Added Benefits

Utility Support Benefit and Healthy Food Benefits

Diamond members will receive \$175 per month and Ruby members will receive \$35 per month for Utility Support and Healthy Food Benefits. Members can use the allowance to pay plan approved utility expenses or buy healthy foods at select retail locations, online, or via catalog. Rollover will be for the first month of enrollment and will expire at the end of the second month. Remaining card allowances will expire at the end of each month and at the end of the calendar year. Fees and plan restrictions apply.

Dental Benefit

Our plans give members an \$8,000 (**Diamond**) and \$3,500 (**Ruby**) allowance for dental care including benefits like:

- Cleanings.
- Oral exams.
- X-rays.
- Crowns.
- Fillings.
- · Root canals.
- Annual coverage for dentures.

Vision Benefit

Every Highmark Wholecare plan includes complete vision coverage. Benefits include an annual eye exam with free glasses or contacts from the Davis Vision collection each year, or up to \$600 (Diamond Plan) \$300 (Ruby Plan) toward your choice of eyewear.

Hearing Benefit

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

Over-The-Counter Benefit

Diamond members can get up to \$1280 per year and Ruby members up to \$560 per year to spend on Brand Name and Generic OTC products. This is a quarterly benefit, so allowances don't carry over to the next quarter.

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

Every Highmark Wholecare Medicare Assured Diamond plan includes combined free transportation to non-emergency medical appointments and medical appointments. Members can get up to 100 free rides within a 60-mile radius to:

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

Diamond Plan members can get extra milage with prior approval based on plan limits for medical related trips only. Milage reimbursement is available when a personal car is used.

Every Ruby plan includes free transportation to 30 one-way trips to plan approved health related locations. Mileage reimbursement is available when a personal car is used. Trip limit of 60-mile radius one way with prior approval for extra mileage based on plan limits.

Fitness Benefit

The SilverSneakers program provides access to fitness and wellness classes at health clubs across the country at no extra cost. Your clients can get fit, make friends, and live a healthier, more active life with this program. Members can visit over 14,000 facilities nationwide, with cardio and weight equipment, pools, saunas, and exercise classes taught by certified senior fitness instructors.

2024 Pharmacy Network Updates

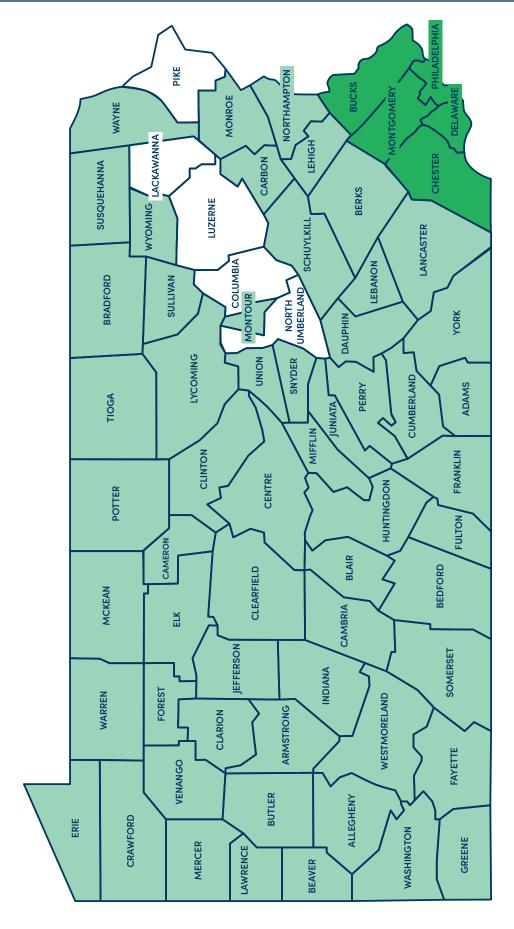


Select local pharmacies are also in-network.

SECTION IV: HIGHMARK WHOLECARE

Products and Pricing by County

Highmark Wholecare Medicare Assured Diamond



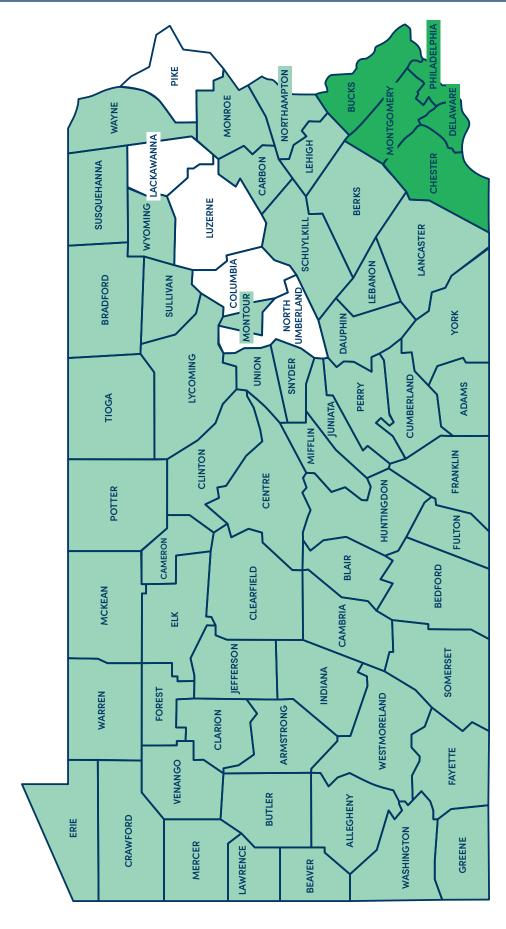
Highmark Wholecare Medicare Assured Diamond 001

Highmark Wholecare Medicare Assured Diamond 012

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

0 11	•
Monthly Flan Fremum Out-of-Pocket Maximum	\$9,850 OOP Max
CP Office Visit	\$0 Copay
Specialist Office Visit	SOCopay
Lab and Diagnostic Tests (Phys. Office or Freestanding Lab)	\$0 Copay and Authorization required
Lab and Diagnostic Tests (Outpatient Facility)	SUCCOPAY ON A University of Control of Contr
Radiation Therapy	SO and Authorization required
Preventive/Screening	SO Copay
utpatient Physical and Speech Therapy	\$0 Copay and Authorization required
Outpatient Mental Health	\$0 Copay for Individual and Group Sessions
utpatient Substance Abuse	A SOCOPAN
Medicare Covered Acupuncture	\$0 Copay and Authorization required
Ambulance Ambulance	\$0 Copay for Ground and Air. Authorization required for Non–Emeraency Medicare Services
Non-Emergency Medical Transportation	Transportation for medical needs (supplemental benefit) and transportation for non-medical needs (VBII) are a combined limit of 100 one-way trips to plan approved locations. Mileage reimbursement is available when a personal car is used. Trip limit
	ot bu mile radius one way, Extra mileage may be grantea with prior approval based on plan limits for medical related trips only. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply.
Emergency Room	SOCopay
Urgent Care	\$0.Copay
Inpatient Hospital Stay (Acute and Psychiatric)	SO and Authorization required SO and Authorization required
Home Health	So and Authorization required
abetic Supplies and Services	\$0 Copay
отс	\$320 every three months; allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, so a new member will receive the full allowance regardless of when they jain in the quarter. An OTC catalog of CMS-approved non-prescription over-the-counter medications and health-related thems is available, COVID-19 tests are included. Quantity limits and plan restrictions apply.
urable Medical Equipment	SO Copay and Authorization required
Meal Benefit	Beneficiary will be eligible for the benefit upon discharge from inpatient stay at hospital/rehab/skilled nursing facility as monitored
Fitness Benefit	by the plan. Plan restrictions apply. Plan covers 28 medis over 14 days, no limit for the number of admissions. Provides membership at participating network fifness centers at no cost
Home and Bathroom Safety Devices and Modifications	Benefit coordinated through Highmark Wholecare Case Management Department.
Personal Emergency Response System (PERS)	Limited to six Bathroom Safety devices per year. Benefit coordinated through Highmark Wholecare Health Case Management Department.
-	Limited to one PERS device per member per lifetime.
General Supports for Living	\$175 every month for Healthy Benefits. Members can use the allowance to pay plan approved utility expenses or to purchase healthy foods at select retail locations, online, or via catalog. Rollover will be for the first month of enrollment and will expire at the end of the second month, remaining card allowances will expire at the end of each month and at the end of which second month, remaining card allowances will expire at the end of each month and at the end of the calendar vear. Fees and plan restrictions apply.
ransportation for Non-Medical Needs	Transportation for medical needs (supplemental benefit) and transportation for non-medical needs (VBID) are a combined limit of 100 one-wort pries to plan a paroved locations. This limit of 60 miles radius one way, Beneficiary must call noted transportation vendor to receive service. Schedulina rules and olan restrictions apply.
Additional Telehealth Services	Services covered with applicable Copay listed for outpatient
Part B Drugs	\$0 Copay and Prior authorization required for certain prescription drugs
Medicare Covered Vision (Office Visit) Pourtine Vision (Office Visit)	\$0 Copay
Roufine Vision (Eyewear)	\$600 every year limited to ano (1) pair of frames or contact lenses each year. Member options include vendor frames or standard contact lenses at no cost per calendar year when purchased from vendor vision collection, or \$600 toward non-vendor frames or non-vendor contact lenses per calendar year. Standard lanses rowered in fill from either online.
Medicare Covered Hearing Exam	
Routine Hearing Exam	\$0 Copay; one visit per year
Routine Hearing (Hearing Aids)	Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing-branded Advanced hearing aids, \$0 copayment per aid. You must see a TruHearing provider to use this benefit.
Routine Dental	\$8,000 every year (combined with Comprehensive); One oral exam every six months; four cleanings every six months; Other X-ray includes; Panoramic and full mouth X-rays once every five years, bitewing, periopical and occlused X-rays once every six maniths.
Medicare Covered Comprehensive Dental	\$0 Copay Authorization may be real lited for Medicate covered services
Comprehensive Dental — Supplemental	S8,000 every year (combined with Routine), Amalgam or resin fillings unlimited; Crowns limited to two peryear, one crown in five years per Post, Scaling and roto plaining limit four quads per visit with each quad once every year, full mouth debridement one peryear, and any combination of routine prophylaxis and periodontal maintenance (D1110 and b949) to ylading you per year, simple extractions only, dentures are covered one per arch every year maintenance (D1110 and b949) to ylading you per year, simple extractions only, dentures are covered one per arch every year maintenance (D1110 and b949) to ylading you per year, simple extractions only, dentures are covered one per arch every year.
Medicare Covered Chiropractic	\$0 Copay and Authorization required
outine Chiropractic	\$0 Copay and Authorization required
Medicare Covered Podiatry Routine Podiatry	SO CODAY SO CODAY
Cardiac and Pulmonary Rehab and SET,	1-11-US
artial Hospital, Outpatient Blood	Andon or

Highmark Wholecare Medicare Assured Ruby



Highmark Wholecare Medicare Assured Ruby 009

Highmark Wholecare Medicare Assured Ruby 013

*Pricing is subject to CMS approval

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

ssts (Phys. Office or Freestanding Lab) ssts (Outpatient Facility) add Speech Therapy adith s Abuse supuncture Services ical Transportation y (Acute and Psychiatric) y	SB_700 OOP Max SB_Copay SD Copay SDC Copay and Authorization required SDC Copay and Authorization required SDC Copay and Authorization required SDC Copay for Diagnastic SBO for Therapeatic and Authorization required SDC Copay (SDC Copay and Authorization required SDC Copay (SDC Copay and Authorization required SDC Copay (SDC Copay and Authorization required SDC Copay and Authorization required Trip limit of 60 mile radius one way with prior approval for extra mileage based on plan limits. Beneficiary must call noted Trip limit of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted Trip limit of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted Trip limit of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary for the same condition and cannot be applied towards deductible SDC Copay S140 Every three months; allowance will not cave for the full allowance regardleds of when they join in the quarter. An OTC catalog of CMS-approved non-prescription over-the-counter medications and plan restrictors apply. An OTC catalog of CMS-approved non-prescription over-the-counter medications and plan restrictors avoidable.
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re sportation and Psychiatric)	S25 Copay for Individual and Group Sessions S25 Copay for Individual and Group Sessions S25 Copay and Authorization required S250 for Ground and Air. Authorization required for Non-Emergency Medicare Services eway trips to plan approved health related locations. Mileage relaturesement is available when a personal car is used. Itin of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply. S250 Copay Days 1 to 8/30 Copay Days 1 to 9/30 Copay Days 1 to 100 and Authorization required S0 Copay Days 1 to 20/3203 Copay Days 2 to 100 and Authorization required S0 and Authorization required to following quarter. There is no praction on the apparent in receive the full allowance regardless of when they join in the quarter. S150 Copay Days 1 to 20/3203 Copay Days 2 to 100 and Authorization required and apply to a new member will receive the full allowance regardless of when they join in the quarter. S160 Copay Days 1 to 20/3203 Copay Days 1 to 100 and Authorization required and apply to 100 and Authorization required and apply to 100 and Authorization verther-counter negative and plan they join in the quarter. S170 Catalog of CMS-approved non-prescription over the -counter medications and plan in the quarter.
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sportation and Psychiatric)	\$250 for Ground and Air Authorization required \$255 for Ground and Air Authorization required \$255 for Ground and Air Authorization required for Non-Emergancy Medicare Services way trips to plan approved health related locations. Mileage reimbursement is available when a personal car is used it of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted transpartation vendor to receive service. Scheduling rules and plan restrictions apply. 355 Copay \$250 Capay Days I to 8/30 Capay \$30 Capay Days I to 8/30 Capay Days I to 8/30 Capay \$30 Capay Days I to 8/30 Capay Days I to 8/30 Capay \$30 and Authorization required \$30 and Authorization required \$30 capay as a new member will receive the fall allowance regardless of when they join in the quarter. The quarterly allowance, as an ew member will receive the fall allowance regardless of when they join in the quarter. SO Capay Days I to 8/30 Capay Days I to 8/30 Capay and Pathorization required \$30 and Authorization required
sportation and Psychiatric)	\$250 for Ground and Air. Authorization required for Non-Emergency Medicare Services way trips to plan approved health redited locations. Mileage reinbursement is available when a personal car is used. into f60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted transportation vendor to receive service. Scheduling rules and plan restrictions apply. It is a service in the same condition and cannot be applied towards deductible as will be waived if admitted to Hospital within 24 hours for the same condition and cannot be applied towards deductible as \$250 Capay Days 1 to \$20/\$203 Capay Days 7 to 90 and Authorization required \$0 Capay Days 1 to \$20/\$203 Capay Days 7 to 90 and Authorization required \$0 Capay Size on every forward to following quarter. There is no proration on the quarter, and every forward to following quarter. There is no proration on the quarter of capacity and every forward to following quarter and every forward to follow over-the-counter neglicitions and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
portation ind Psychiatric)	way trips to plan approved health related locations. Mileage reimbursement is available when a personal car is used, ait of 60 mile radius one way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted tradisco ne way way with prior approval for extra mileage based on plan limits. Beneficiary must call noted transportation vendor to receive service. Scheduling tules and plan restrictions apply. 100 plan service. Scheduling tules and plan restrictions applied towards deductible as will be waived if admitted to Hospital within 24 hours for the same condition and cannot be applied towards deductible. 100 plan service and plan restrictions applied towards deductible as services. Scheduling the service has a solid plan restriction required solid plan service will not carry forward to following quarter. There is no proration on the quarterly allowance will receive the full allowance regardless of when they join in the quarter. 100 plan service the full allowance regardless of when they join in the quarter. The carried and plan restrictions and health-related items is available. 100 COVID-19 tests are included. Quantity limits and plan restrictions apply.
ind Psychiatric)	transportation vendor to receive service. Scheduling rules and plan restrictions apply. sy will be waived if admitted to Hospital within 24 hours for the same condition and cannot be applied towards deductibite some condition and cannot be applied towards deductibite some some some some some some some som
ind Psychiatric)	ay will be waived if admitted to Hospital within 24 hours for the same condition and cannot be applied towards deductible \$250 Copay \$250 Copay Days 1 to 6/80 Copay Days 7 to 90 and Authorization required \$0 Copay Days 1 to 20/8203 Copay Days 21 to 100 and Authorization required \$0 Copay Days 1 to 20/8203 Copay Days 21 to 100 and Authorization required \$0 Copay Days 1 to 20/8203 Copay Days 21 to 100 and Authorization required \$0 Copay \$140 Every three months, allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, so a new member will receive the full allowance regardless of when they join in the quarter. The catalog of CMS-approved non-prescription over-the-counter medications and health-related items is available, COVID-19 tests are included. Quantity limits and plan restrictions apply.
nd Psychiatric)	\$250 Capay Days 1 to 6/80 Capay Days 2 to 90 and Authorization required \$0 Capay Days 1 to 20/\$203 Capay Days 2 to 100 and Authorization required \$0 Capay Days 1 to 20/\$203 Capay Days 2 to 100 and Authorization required \$0 Capay Days 1 to 20/\$203 Capay Days 2 to 100 and Authorization required \$0 Capay three months; allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, and in the properties of the following quarter regardless of when they join in the quarter. The counter medications and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
ind respondency	So Capay Days 1 to 20/8203 by 1995 1 to 3 and Authorization required \$0 Capay Days 1 to 20/8203 by 21 to 100 and Authorization required \$0 Capay Days 1 to 20/8203 by 21 to 100 and Authorization required \$140 Every three months; allowance will not carry forward to following quarter. There is no proration on the quarterly allowance will receive the full allowance regardless of when they join in the quarter. The capapoved non-prescription over-the-counter medications and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
	SD and Authorization required SO Copay \$140 Every three months; allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, so a new member will receive the full allowance regardless of when they join in the quarter. TC catalog of CMS-approved non-prescription over-the-counter medications and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
	\$0 Copay \$140 Every three months; allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, so a new member will receive the full allowance regardless of when they join in the quarter. OTC catalog of CMS-approved non-prescription over-the-counter medications and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
	\$140 Every three months, allowance will not carry forward to following quarter. There is no proration on the quarterly allowance, so a new member will receive the full allowance egardless of when they join in the quarter. OTC catalog of CMS-approved non-prescription over-the-counter medications and health-related items is available. COVID-19 tests are included. Quantity limits and plan restrictions apply.
And	
Durable Medical Equipment	20% Coinsurance and Authorization reauired
	Beneficiary will be eligible for the benefit upon discharge from inpatient stay at hospital/rehab/skilled nursing facility as
	monitored by the plan. Plan restrictions apply. Plan covers 14 meals over seven days, no limit for the number of admissions.
Fitness Benefit	Provides membership at participating network fitness centers at no cost
Home and Bathroom Safety Devices and Modifications	Benefit coordinated through Highmark Wholecare Case Management Department. Limited to two Bathroom Safety devices per vear.
Personal Emergency Response System (PERS)	Benefit coordinated through Highmark Wholecare Health Case Management Department. Limited to one PERS device per member per lifetime.
General Supports for Living pu pu and and	\$35 every month for Healthy Benefits. Members can use the allowance to pay plan approved utility expenses or to purchase healthy foods at select retail locations, online, or via catalog. Rollover will be for the first month of enrollment and will expire at the end of the second month, remaining card allowances will expire at the end of each month and at the
Transportation for Non-Madical Needs	end or me calendar year, rees and plan restrictions apply.
Additional Telebeath Services	Sarvines covered with analizable for authorisant
Part B Drugs	\$35 capary for Part B covered insulin. (ASS required in 2024.) 20% coinsurance for all other Part B covered druas.
Medicare Covered Vision (Office Visit)	\$0 Copay for diabetic retinal eye exam; \$25 Copay applies to all other Medicare-covered benefits
£	\$0 Copay; one visit per year
Routine Vision (Eyewear) \$200e	\$2000 every year limited to one pair of frames or contact lenses each year. Member opiions include vendor frames or standard contact lenses at no cost per calandary early when purchased from wendor vision collection, or \$200 toward non-vendor frames or non-vendor contact lenses at no cost per calandary eyea. Standard lenses covered in full for either opiion. Plan restrictions apply,
aring Exam	\$25 Copay
	\$0 Copay; one visit per year
Routine Hearing (Hearing Aids)	Up to two TruHearing-branded hearing aids every three years (one per ear every three years). Benefit is limited to TruHearing-branded Advanced hearing alas, 80 copayment per aid for TruHearing Advanced. You must see of TruHearing provider to use this benefit.
Routine Dental	One oral exam every six months; four cleanings every six months; Other X-ray includes: Panoramic and full mouth X-rays once every five years, bitewing, periapical and occlusal X-rays once every six months.
Medicare Covered Comprehensive Dental	\$25 Minimum Copay and \$250 Maximum Copay; Authorization may be reaulied for Medicare covered services
Comprehensive Dental — Supplemental Scalin S	\$33.500 every year, Amalgam or resin fillings unlimited; Crowns limited to one per year, one crown in five years per tooth. Scaling and root planing limit four quads per visit with each quad once every two years, full mount debridament one per year, and any combination of routine prophylaxis and periodonial manitenance (U110 and D490) totaling four per year; Simple extractions only dentures are covered one per arch every five years, including of full denture, a partial denture or an simple extractions only denture are covered one per arch every five years, including of full denture, a partial denture or an immediate denture and are not abolish of the comprehensive moximum plan coverage amount
Medicare Covered Chiropractic	\$15 Copay and Authorization required
Routine Chiropractic	\$15 Copay and Authorization required
Medicare Covered Podiatry Routine Podiatry	\$25 Copay \$25 Copay
Cardiac and Pulmonary Rehab and SET,	\$0 Copay
dina noshia, capanen bood	Orivo Orivo
Part D Reduced Cost Sharing	30 Convon all tiers (1–5) in all roverna pariods

Pennsylvania

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby	
	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 Kennedy	•	•	
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 Presbyterian Shadyside Hospital	·	→	
UPMC St. Margaret Hospital	•	·	
Armstrong County			
Armstrong County Memorial Hospital			
	Beaver County		
Heritage Valley Beaver	~	·	
	Bedford County		
UPMC Bedford Memorial	→	→	
	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 State of the State			
Conemaugh Nason Medical Center	~	~	
Penn Highlands Tyrone	~	·	
UPMC Altoona	•	~	
	Bradford County		
Guthrie Robert Packer Hospital Acute Rehab	~	→	
Guthrie Troy Community Hospital	•	·	
Guthrie Robert Packer Hospital	•	•	
Robert Packer Hospital — Towanda Campus	•	·	

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby	
	Bucks County		
Aria Health — Bucks Campus	~	·	
Avenues Recovery Medical Center at Valley Forge	•	~	
Lower Bucks Hospital	•	→	
St. Luke's Quakertown Hospital	•	→	
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			
Thousand the second sec	Clarion County	-	
Clarion Hospital	- Clarion County	·	
	Clearfield County	·	
Penn Highlands Clearfield	v	,	
Penn Highlands Dubois	· · · · · · · · · · · · · · · · · · ·	·	
reminighands bubbis	Clinton County	•	
Bucktail Medical Center	Cilifor County -		
Buckfall Medical Center		,	
Meadville Medical Center	Crawford County		
	Y	,	
Titusville Area Hospital			
D. 01 - H. H. H. C. 2 H. 2 L.	Cumberland County		
Penn State Health Holy Spirit Hospital	· ·	~	
Holy Spirit Silver Creek Mediplex	· ·	<u> </u>	
Penn State Health Hampden Medical Center	· ·	<u> </u>	
UPMC Pinnacle Carlisle	· · · · · · · · · · · · · · · · · · ·	·	
	Dauphin County	T	
Penn State Health Milton S. Hershey Medical Center	~	~	
UPMC Pinnacle Community Osteopathic	· · · · · · · · · · · · · · · · · · ·	, , , , , , , , , , , , , , , , , , ,	
Delaware County			
Crozer Health — Chester Medical Center	·	·	
Crozer Health — Delaware County Memorial Hospital	·	·	
Mercy Catholic Medical Center Fitzgerald Campus	·	·	
Main Line Health — Riddle Hospital	·	·	
Crozer Health — Springfield Hospital	~	·	
Crozer Health — Taylor Hospital	•	✓	

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby	
	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		
WYU 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 Pinnacle 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	·	·	
	Lycoming County		
UPMC Muncy Valley Hospital	· ·	·	
Williamsport Regional Medical Center	·	•	
· •			

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby		
	McKean County	<u>'</u>		
UPMC Kane Community Hospital	·	·		
	Mercer County			
AHN Grove City Hospital	·	·		
Edgewood Surgical Hospital	·	·		
Steward Sharon Regional Health System	·	·		
UPMC Horizon	·	·		
	Monroe County			
Lehigh Valley Hospital — Pocono	· ·	·		
St. Luke's Hospital — Monroe Campus	·	~		
	Montgomery County			
Einstein Medical Center — Montgomery	· ·	·		
Lankenau Medical Center	·	·		
Pottstown Hospital	·	·		
Suburban Community Hospital	·	·		
Northampton County				
Lehigh Valley Hospital — Muhlenberg	·	·		
Lehigh Valley Hospital Coordinated Health Bethlehem	·	·		
Saint Lukes Hospital of Bethlehem, Pennsylvania	·	·		
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 PA	▽	·		
Jeanes Hospital	✓	~		
Kensington Hospital	·	V		
Mercy Catholic Hospital — PhiladelphiaCampus	·	V		
Nazareth Hospital	·	~		
Penn Presbyterian Medical Center	·	V		
Pennsylvania Hospital	·	V		
Roxborough Memorial Hospital	·	·		
Temple University Hospital	·	·		
Wills Eye Hospital	·	V		
	Potter County			
Charles Cole Memorial Hospital	·	~		

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby	
	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	•	~	
Venengo 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 Pinnacle Hanover	·	·	
UPMC Pinnacle Memorial	·	·	
WellSpan Philhaven Child Partial Hospitalization	·	·	
WellSpan York Hospital	·	·	
	·	→	

Delaware

New York

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby
New Castle County		
Christiana Care Health Services Inc.	~	~

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby
Cattaraugus County		
Olean General Hospital	~	~
Cortland County		
Guthrie Cortland Medical Center — Cancer Center	~	~
Steuben County		
Guthrie Corning Hospital	•	•

West Virginia

WVU Medicine — St. Joseph's Hospital

WVU Medicine — Wetzel County Hospital

Facility Name Assured Assured Diamond Ruby **Berkeley County** Berkeley Medical Center **Jefferson County** Jefferson Medical Center **Marshall County** Reynolds Memorial Hospital Inc. **Mineral County** Potomac Valley Hospital of WV Inc **Monongalia County** West Virginia University Hospitals Inc. **Upshur County**

Wetzel County

Medicare

Medicare

New Jersey

Facility Name	Medicare Assured Diamond	Medicare Assured Ruby
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.	•	~

SECTION IV: HIGHMARK WHOLECARE

Additional Resources

Scope of Appointment Confirmation Form

Highmark Wholecare offers individuals the following products:

Medicare Special Needs Plans (HMO SNP)		
For individuals entitled to Medicare Part A, enrolled in Medicare Part B, who live in the service area and receive Medicaid Assistance from the State.		
Please indicate how you wish to be contacted:		
☐ I would like an agent to call me.	☐ I would like an agent to meet with me in person.	
Beneficiary information		
Name:		
Address:		
Phone number:		
In the space provided below, please initial the type disucss:	of Medicare Advantage product(s) you want the agent to	
Medicare Special Needs Plans (HMO SI	NP)	
Please remember to sign and date this form on the	back side of this page.	

Signature:	Date:
If you are the authorized representative	ase sign above and print below:
Name:	
Relationship to beneficiary:	
nitialed above. Please note, the per Medicare plan. The person does not	who will discuss the products is either employed or contracted by a directly for the Federal Government. This individual may also be paing this form does NOT obligate you to enroll in a plan, affect your dicare plan.
To be completed by Agen	Phone:
Name: Initial method of contact: (Please indicate if beneficiary v	Phone: walk-in)
Name: Initial method of contact:	
Name: Initial method of contact: (Please indicate if beneficiary v	walk-in)
Name: Initial method of contact: (Please indicate if beneficiary v	walk-in)

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Highmark Wholecare:

Provides free aids and services to people with disabilities to communicate effectively with us, such as: o Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- o Qualified interpreters
- o Information written in other languages

If you need these services, contact Member Services at 1-800-685-5209, 8 a.m - 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m. – 8 p.m., Monday through Friday. TTY users should call 711.

If you believe that Highmark Wholecare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Appeals and Grievances Attention: 1557 Coordinator

PO Box 22278

Pittsburgh, PA 15222

Phone: 1-844-207-0336 Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Appeals and Grievances is available to help you. Additional information can be found at https://highmarkwholecare.com/nondiscrimination-notices.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-685-5209 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-685-5209 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务,帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务,请致电 1-800-685-5209 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問,為此我們提供免費的翻譯 服務。如需翻譯服務,請致電 1-800-685-5209 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-685-5209 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-685-5209 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-685-5209 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheitsund Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-685-5209 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-685-5209 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-685-5209 (ТТҮ 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، Arabic: . بسقوم شخص ما يتحدث العربية (TTY 711) 800-685-509-1ليس عليك سوى الاتصال بنا على

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-685-5209 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-685-5209 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-685-5209 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-685-5209 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-685-5209 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-685-5209 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Highmark Wholecare offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal. Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare").

NS_2801_C (10/2022)

Agent Sales Checklist

To enroll a new member, you need their:		
	Name	
	Address	
	Date of birth	
	Social Security Number	
	Medicaid and Medicare numbers (if available)	
	List of current doctors and prescriptions	

How to check eligibility

To check a member's eligibility, you can either call Agent Support or use one of the programs mentioned below to do it yourself. Here's how:

- 1. Make sure you have a POT (Permission to Contact)/Scope of Appointment.
- Have the member's name, address, and date of birth handy. If you're calling Agent Support, you should also have their Social Security Number (SSN) and Medicare Beneficiary Number (MBI), if possible.
- 3. If the member already has a Medicare plan, you use their Medical Assistance Number, Eligibility Code, or SSN to look them up.
- 4. Sign into all programs (Cavulus, ECIS, MARx, Provider network tool, and Formulary tool) or call Agent Support. Use the member's information to find them in the programs, or provide their information to Agent Support.
- 5. Check for eligibility. Make sure you take notes and capture all information connected to the member.

SECTION V

Highmark ACA Individual Market

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Vision and Dental
Additional Resources
ICHRA

Enrollment Processes

For Plan Year 2024: Open Enrollment Period

Nov. 1, 2023 – Jan. 15, 2024 (DE, PA, WV)

Nov. 16, 2023 – Jan. 31, 2024 (New York)

Members who enroll by Dec. 15, 2023 will have a plan effective date of Jan. 1, 2024. Members who enroll in a plan between Dec. 16, 2023 and Jan. 15, 2024 will have a plan effective date of Feb. 1, 2024.

Financial assistance

There are two kinds of extra cost savings available for Affordable Care Act (ACA) enrollees.

Advanced Premium Tax Credits (APTC)

APTC may be applied, in advance, to lower payments each month for premiums at any level Marketplace plan except Catastrophic.

Cost-Sharing Reductions (CSR)

CSR will lower deductibles and out-of-pocket costs that a member may pay at the time of service for doctor visits, lab tests, drugs, and other covered services. These savings are only available with enrollment in a Marketplace Silver plan. These plans will have the term **Extra Savings** in the name.

Special Enrollment Period

Special Enrollment Periods can apply any time throughout the year. Outside the Open Enrollment Period, members may only change or enroll in coverage if they have a qualifying life event.

Examples include:

- Losing eligibility for employer-sponsored coverage due to job loss, reduction in hours, or employer no longer offering benefits or closes.
- Expiration of COBRA coverage or non-calendar year policy.
- Losing pregnancy-related or medically necessary coverage under Medicaid.
- · Losing eligibility for Medicaid or CHIP.
- Losing eligibility for Medicare.
- Having a baby.
- · Getting married.

Deadline for Loss of Minimum Essential

Coverage: The application, SEP form, and supporting documentation must be submitted within 60 days after coverage is lost. In some cases, but not all, the application may be submitted up to 60 days before the loss of coverage.

Effective date: In most cases, this may be the first day of the month immediately following the application, or the second month after the application, depending on the type of special enrollment and date of application.

Note: Voluntarily quitting other health insurance coverage, being terminated for not paying premiums, or losing health insurance coverage that does not qualify as minimum essential coverage are not considered a loss of qualifying coverage. A conversion or HIPAA plan may be a good option if your client's policy terms prior to end of month.

Once an application is approved, the member will receive:

- An enrollment confirmation email received the next business day after application confirmation.
- A payment confirmation email and SMS received the next business day after payment confirmation.
- A member ID card and buckslip received within seven business days of their active enrollment date.
- A welcome email or SMS received within the first 14 business days of enrollment.
- A welcome booklet received within the first 30–60 business days of enrollment.

Member eBill registration

The simplest way for your client to pay their bill is by registering for an eBill account. Once they make their first payment and it's received, they can set up automatic payments to ensure they never miss one.

Refer to page page 15 for information on how to enroll and utilize eBill.

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.
- Access to a dedicated Together Connect Team —
 on hand to help them navigate all the ins and outs
 of their care and coverage when they receive
 services from an AHN provider.
- Plans that are available on- and off-exchange.

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

Together Blue EPO Product Changes

- The Together Blue Diabetes and Together Blue Diabetes + Adult Dental and Vision plans will be discontinued in 2024. All impacted members will be transitioned to the Together Blue Gold 0 (or with Adult Dental and Vision, if applicable).
- Introduction of Together Blue Gold 1500 Virtual Choice plan which will offer low virtual copays for PCP, Specialist, Mental Health/Substance Abuse, and Urgent Care.
- 3. The Papa Pals program will be removed from all Premier level Together Blue EPO plans.

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 Direct Blue EPO Product Changes

- The service area for my Direct Blue EPO has been revised to remove Blair, Somerset, Fayette and Greene counties. Impacted members will be transitioned to the appropriate my Blue Access PPO plan.
- Introduction of a low-deductible gold plan (Gold 1500) to meet the needs of consumers who are looking for a cost-effective option at the Gold metallic tier.
- 3. The Papa Pals program will be removed from all Premier level my Direct Blue EPO plans.

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 now 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 Blue Access PPO Product Changes

- 1. Expansion into the five-county southeastern region.
- 2. Introduction of a low-deductible gold plan (Gold 1500) to meet the needs of consumers who are looking for a cost-effective option at the Gold metallic tier.
- 3. The Papa Pals program will be removed from all Premier level my Blue Access PPO plans.

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 DE PPO

my Blue Access DE 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 innetwork 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

Available in eight counties in the western New York service area and 13 counties in the eastern New York service area, Point of Service plans include:

- In-network access to doctors and hospitals almost everywhere through the national BlueCard network.
- Pediatric, dental, and vision on all plans.
- Adult dental and vision on select plans at every metal level.
- Plans available on-and off-exchange.

Value-Added Benefits

The **Mental Wellbeing** solution offers fast, expanded access to a network of high-quality mental health providers, using actionable data to deliver the right care for each member. This includes digital exercises, care navigation, coaching, therapy, medication management, and a 24/7/365 crisis support line. After enrolling, members are asked to complete an assessment that creates a care pathway based on their answers. Interventions range from self-guided activities to clinical appointments. This program is available to members 6 years and older, and offered to MA and ACA members as part of their medical benefits.

Well360 Virtual Health powered by American

Well is a virtual care solution that provides Urgent Care, Behavioral Health, Virtual Primary Care, Dermatology, and Women's Health services. Members will easily and seamlessly access the entire suite of Well360 Virtual Health practices through our fully integrated My Highmark/Beneficity experience. Well360 Virtual Health is available to MA and ACA members as a part of their medical benefits.

Benefits include:

- On-demand or scheduled appointments.
- Easy access to all practices via My Highmark and Beneficity apps and websites
- 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.
- Smaller care gaps and faster-time-to-treatment options with Dermatology and Behavioral Health.
- Expanded access to Primary Care.

Highmark's Virtual Physical Care Program Powered by Sword

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

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

Kidney Care Management (Healthmap)

Your clients with CKD and ESRD have complex treatment plans that often result in high-cost utilization and poor member experience. This solution works to support your client 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 Healthmap Solutions (Healthmap) Kidney Care Management program. By enrolling, they'll 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.

CHF and COPD Management powered by Vida*

CHF and COPD Management powered by Vida aims to help those with Chronic Obstructive Pulmonary Disease (COPD) or Congestive Heart Failure (CHF) better manage their condition, reduce or avoid hospital admissions, readmissions, and ER visits. The virtual solution allows your clients to learn how to expertly recognize, manage and monitor their symptoms all while utilizing the help of registered dietitians, health coaches, in-app trackers, lessons on symptom monitoring, regular mental health assessments, and monitoring devices. When needed, a patient will have access to digital scales, blood pressure monitoring devices, digital scales, and respiratory tracking devices.

2024 Pharmacy Network Updates

	In Network		OON
PA	Costco CVS/Target Giant Eagle GIANT The Medicine Shoppe Rite Aid Sam's Club	Sav-On Walmart Wegmans Weis Select Specialty Pharmacies Select Independent Pharmacies	Walgreens
wv	CVS/Target Sam's Club The Medicine Shoppe Walgreens	Walmart Select Specialty Pharmacies Select Independent Pharmacies	
DE	CVS/Target Rite Aid Sam's Club Sav-On	Walgreens Walmart Select Specialty Pharmacies Select Independent Pharmacies	
New York	Costco CVS/Target Kinney Drugs Price Chopper Rite Aid Sam's Club Stop and Shop	The Medicine Shoppe Tops Walgreens Walmart Wegmans Select Specialty Pharmacies Select Independent Pharmacies	

SECTION V: ACA INDIVIDUAL MARKET

Products and Pricing by County

Western Pennsylvania

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	BRONZE HSA 7100 Custom Drug Benefit	BRONZE 3800
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$3,800 Family: \$7,600
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$65 copay X-ray: \$150 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	50%/50%/50%/50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

Western Pennsylvania, cont.

Coverage Level	SILVER 7000	PREMIER SILVER 2900	SILVER* 3500 (Off Exchange only)	GOLD 0
Plan Availability	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO	Together Blue EPO my Direct Blue EPO my Blue Access PPO
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$2,900 Family: \$5,800	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,500 Family: \$17,000	Individual: \$9,350 Family: \$18,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Specialist Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$75 copay	\$75 copay	\$75 copay	\$35 copay
Urgent Care	\$100 copay	\$100 copay	\$90 copay	\$40 copay
Emergency Services	\$750 after deductible	\$750 after deductible	30% after deductible	\$300 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	30% after deductible	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

Western Pennsylvania, cont.

Coverage Level	PREMIER GOLD 0	GOLD 1500	GOLD HSA 1700
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: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In–Network Out–of–pocket Maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15 copay	\$35 copay	\$20 after deductible
Specialist Visit	\$15 copay	\$35 copay	\$20 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 after deductible
Diagnostic Test (Lab/X-ray)	\$45 copay	\$40 copay	\$20 after deductible
Urgent Care	\$30 copay	\$70 copay	\$40 after deductible
Emergency Services	\$280 copay	\$350 copay	\$175 after deductible
Hospital Inpatient (per visit)	\$525 copay	\$725 copay	\$450 after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	Yes	No	No

^{*}For Together Blue only: The Gold 1500 will be offered as Gold 1500 Virtual Choice which will feature \$0 virtual copays for PCP, Specialist, MH/SA, and urgent care.

Western Pennsylvania — Extra Savings

Income Level	200-249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	PREMIER SILVER 2100	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: \$3,700 Family: \$7,400	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,150 Family: \$6,300
Primary Care Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Specialist Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	\$75 copay	\$25 copay	\$40 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 after deductible	\$750 after deductible	\$275 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

Western Pennsylvania — Extra Savings, cont.

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: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400	
Primary Care Visit	\$1 copay	\$0 copay	
Specialist Visit	\$1 copay	\$0 copay	
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$1 copay	\$0 copay	
Urgent Care	\$5 copay	\$5 copay	
Emergency Services	\$75 copay	\$75 copay	
Hospital Inpatient (per visit)	\$175 copay	\$175 copay	
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%	
Adult Dental and Vision Available	No	Yes	

Central Pennsylvania

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	BRONZE HSA 7100 Custom Drug Benefit	BRONZE 3800
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$3,800 Family: \$7,600
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$65 copay X-ray: \$150 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	50%/50%/50%/50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

Central Pennsylvania, cont.

Coverage Level	SILVER 7000	PREMIER SILVER 2900	SILVER 3500 (Off Exchange only)	GOLD 0
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$2,900 Family: \$5,800	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,500 Family: \$17,000	Individual: \$9,350 Family: \$18,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Specialist Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$75 copay	\$75 copay	\$75 copay	\$35 copay
Urgent Care	\$100 copay	\$100 copay	\$90 copay	\$40 copay
Emergency Services	\$750 after deductible	\$750 after deductible	30% after deductible	\$300 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	30% after deductible	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

Central Pennsylvania, cont.

Coverage Level	PREMIER GOLD 0	GOLD 1500	GOLD HSA 1700
Plan Availability	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO	my Direct Blue EPO my Direct Blue LHV EPO my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In–Network Out–of–pocket Maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15 copay	\$35 copay	\$20 after deductible
Specialist Visit	\$15 copay	\$35 copay	\$20 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 after deductible
Diagnostic Test (Lab/X-ray)	\$45 copay	\$40 copay	\$20 after deductible
Urgent Care	\$30 copay	\$70 copay	\$40 after deductible
Emergency Services	\$280 copay	\$350 copay	\$175 after deductible
Hospital Inpatient (per visit)	\$525 copay	\$725 copay	\$450 after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	Yes	No	No

Central Pennsylvania — Extra Savings

Income Level	200–249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	PREMIER SILVER 2100	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: \$3,700 Family: \$7,400	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,150 Family: \$6,300
Primary Care Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Specialist Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	\$75 copay	\$25 copay	\$40 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 after deductible	\$750 after deductible	\$275 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

Central Pennsylvania — Extra Savings, cont.

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: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400	
Primary Care Visit	\$1 copay	\$0 copay	
Specialist Visit	\$1 copay	\$0 copay	
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$1 copay	\$0 copay	
Urgent Care	\$5 copay	\$5 copay	
Emergency Services	\$75 copay	\$75 copay	
Hospital Inpatient (per visit)	\$175 copay	\$175 copay	
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%	
Adult Dental and Vision Available	No	Yes	

Southeastern Pennsylvania

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	BRONZE HSA 7100 Custom Drug Benefit	BRONZE 3800
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$3,800 Family: \$7,600
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$0 after deductible	\$65 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$55/\$105 copay X-ray: \$125/\$250 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50% after deductible
Pharmacy Summary	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	50%/50%/50%/50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

Southeastern Pennsylvania, cont.

Coverage Level	SILVER 7000	PREMIER SILVER 2900	SILVER 3500 (Off Exchange only)	GOLD 0
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$2,900 Family: \$5,800	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0
In-Network Out-of-pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,500 Family: \$17,000	Individual: \$9,350 Family: \$18,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Specialist Visit	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$45 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$70/\$95 copay	\$70/\$95 copay	\$65/\$115 copay	\$30/\$55 copay
Urgent Care	\$100 copay	\$100 copay	\$90 copay	\$40 copay
Emergency Services	\$750 after deductible	\$750 after deductible	30% after deductible	\$300 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	30% after deductible	\$725 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

Southeastern Pennsylvania, cont.

Coverage Level	PREMIER GOLD 0	GOLD 1500	GOLD HSA 1700
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In–Network Out–of–pocket Maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15 copay	\$35 copay	\$20 after deductible
Specialist Visit	\$15 copay	\$35 copay	\$20 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$35 copay	\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40 copay	\$35 copay	\$20 after deductible
Diagnostic Test (Lab/X-ray)	\$40/\$65 copay	\$35/\$60 copay	\$20 after deductible
Urgent Care	\$30 copay	\$70 copay	\$40 after deductible
Emergency Services	\$280 copay	\$350 copay	\$175 after deductible
Hospital Inpatient (per visit)	\$525 copay	\$725 copay	\$450 after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	Yes	No	No

Southeastern Pennsylvania — Extra Savings

Income Level	200-249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	PREMIER SILVER 2100	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: \$3,700 Family: \$7,400	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,150 Family: \$6,300
Primary Care Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Specialist Visit	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$75 copay	\$15 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$60/\$85 copay	\$70/\$95 copay	\$20/\$45 copay	\$35/\$60 copay
Urgent Care	\$100 copay	\$100 copay	\$30 copay	\$10 copay
Emergency Services	\$750 after deductible	\$750 after deductible	\$275 copay	\$500 copay
Hospital Inpatient (per visit)	\$1,125 after deductible	\$510 after deductible	\$450 copay	\$450 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

Southeastern Pennsylvania — Extra Savings, cont.

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: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	\$1 copay	\$0 copay
Specialist Visit	\$1 copay	\$0 copay
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$0/\$5 copay	\$0/\$0 copay
Urgent Care	\$5 copay	\$5 copay
Emergency Services	\$75 copay	\$75 copay
Hospital Inpatient (per visit)	\$175 copay	\$175 copay
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%
Adult Dental and Vision Available	No	Yes

Northeastern Pennsylvania

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	BRONZE HSA 7100 Custom Drug Benefit	BRONZE 3800
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$3,800 Family: \$7,600
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,100 Family: \$14,200	Individual: \$9,200 Family: \$18,400
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$0 after deductible	\$65/\$80 copay
Specialist Visit	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65/\$80 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65/\$65 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$65/\$80 copay
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	\$0 after deductible	Lab: \$65/\$95 copay X-ray: \$150/\$160 copay
Urgent Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$100 copay
Emergency Services	\$0 after deductible	\$0 after deductible	\$0 after deductible	50%/50% after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	\$0 after deductible	50%/60% after deductible
Pharmacy Summary	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	50%/50%/50%/50% after deductible
Adult Dental and Vision Available	No	No	No	Yes

Northeastern Pennsylvania, cont.

Coverage Level	SILVER 7000	PREMIER SILVER 2900	SILVER 3500 (Off Exchange only)	GOLD 0
Plan Availability	my Priority Blue Flex PPO			
In-Network Deductible	Individual: \$7,000 Family: \$14,000	Individual: \$2,900 Family: \$5,800	Individual: \$3,500 Family: \$7,000	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,500 Family: \$17,000	Individual: \$9,350 Family: \$18,700	Individual: \$7,500 Family: \$15,000
Primary Care Visit	\$55/\$65 copay	\$75/\$90 copay	\$45/\$60 copay	\$20/\$30 copay
Specialist Visit	\$55/\$65 copay	\$75/\$90 copay	\$45/\$60 copay	\$20/\$30 copay
Outpatient Mental Health/Substance Abuse Visits	\$55/\$55 copay	\$75/\$75 copay	\$45/\$45 copay	\$20/\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55/\$65 copay	\$75/\$100 copay	\$45/\$60 copay	\$20/\$30 copay
Diagnostic Test (Lab/X-ray)	\$75/\$90 copay	\$75/\$100 copay	\$75/\$80 copay	\$35/\$50 copay
Urgent Care	\$100/\$100 copay	\$100/\$100 copay	\$90/\$90 copay	\$40/\$40 copay
Emergency Services	\$750/\$750 after deductible	\$750/\$750 after deductible	30%/50% after deductible	\$300/\$300 copay
Hospital Inpatient (per visit)	\$1,125/\$1,360 after deductible	\$510/\$635 after deductible	30%/50% after deductible	\$725/\$885 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%
Adult Dental and Vision Available	No	Yes	Yes	Yes

Northeastern Pennsylvania, cont.

Coverage Level	PREMIER GOLD 0	GOLD 1500	GOLD HSA 1700
Plan Availability	my Priority Blue Flex PPO	my Priority Blue Flex PPO	my Priority Blue Flex PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$3,000	Individual: \$1,700 Family: \$3,400
In–Network Out–of–pocket Maximum	Individual: \$6,550 Family: \$13,100	Individual: \$8,300 Family: \$16,600	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$15/\$25 copay	\$35/\$40 copay	\$20/\$25 after deductible
Specialist Visit	\$15/\$25 copay	\$35/\$40 copay	\$20/\$25 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$15/\$15 copay	\$35/\$35 copay	\$20/\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$40/\$60 copay	\$35/\$40 copay	\$20/\$25 after deductible
Diagnostic Test (Lab/X-ray)	\$45/\$55 copay	\$40/\$50 copay	\$20/\$25 after deductible
Urgent Care	\$30/\$30 after deductible	\$70 copay	\$40/\$40 after deductible
Emergency Services	\$280/\$280 copay	\$350/\$350 copay	\$175/\$175 after deductible
Hospital Inpatient (per visit)	\$525/\$650 copay	\$725/\$885 copay	\$450/\$560 after deductible
Pharmacy Summary	\$0/\$25/\$75/50%	\$0/\$30/\$150/\$1,000	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	Yes	Yes	No

Northeastern Pennsylvania — Extra Savings

Income Level	200-249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	PREMIER SILVER 2100	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: \$3,700 Family: \$7,400	Individual: \$2,100 Family: \$4,200	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In-Network Out-of-pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,150 Family: \$6,300
Primary Care Visit	\$55/\$65 copay	\$75/\$90 copay	\$15/\$25 copay	\$0/\$15 copay
Specialist Visit	\$55/\$65 copay	\$75/\$90 copay	\$15/\$25 copay	\$0/\$15 copay
Outpatient Mental Health/Substance Abuse Visits	\$55/\$55 copay	\$75/\$75 copay	\$15/\$15 copay	\$0/\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55/\$65 copay	\$75/\$100 copay	\$15/\$25 copay	\$0/\$15 copay
Diagnostic Test (Lab/X-ray)	\$65/\$80 copay	\$75/\$100 copay	\$25/\$35 copay	\$40/\$50 copay
Urgent Care	\$100/\$100 copay	\$100/\$100 copay	\$30/\$30 copay	\$10/\$10 copay
Emergency Services	\$750/\$750 after deductible	\$750/\$750 after deductible	\$275/\$275 copay	\$500/\$500 copay
Hospital Inpatient (per visit)	\$1,125/\$1,360 after deductible	\$510/\$635 after deductible	\$450/\$560 copay	\$450/\$560 copay
Pharmacy Summary	\$0/\$30/\$150/50%	\$0/\$30/\$150/50%	\$0/\$10/\$50/50%	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

Northeastern Pennsylvania — Extra Savings, cont.

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: \$1,200 Family: \$2,400	Individual: \$1,200 Family: \$2,400
Primary Care Visit	\$1/\$5 copay	\$0/\$5 copay
Specialist Visit	\$1/\$5 copay	\$0/\$5 copay
Outpatient Mental Health/Substance Abuse Visits	\$1/\$1 copay	\$0/\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$1/\$5 copay	\$0/\$5 copay
Diagnostic Test (Lab/X-ray)	\$1/\$5 copay	\$0/\$5 copay
Urgent Care	\$5/\$5 copay	\$5/\$5 copay
Emergency Services	\$75/\$75 copay	\$75/\$75 copay
Hospital Inpatient (per visit)	\$175/\$210 copay	\$175/\$210 copay
Pharmacy Summary	\$0/\$5/\$15/50%	\$0/\$5/\$15/50%
Adult Dental and Vision Available	No	Yes

West Virginia

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	STANDARD BRONZE 7500	BRONZE HSA 7100 Custom Drug Benefit
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,500 Family: \$15,000	Individual: \$7,100 Family: \$14,200
In-Network Out-of-pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$9,400 Family: \$18,800	Individual: \$7,100 Family: \$14,200
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$50 copay	\$0 after deductible
Specialist Visit	\$0 after deductible	\$0 after deductible	\$100 copay	\$0 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Urgent Care	\$0 after deductible	\$0 after deductible	\$75 copay	\$0 after deductible
Emergency Services	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Pharmacy Summary	\$0/\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$25/\$50/\$100/\$500 after deductible	\$0/\$0/\$0/\$0 after deductible
Adult Dental and Vision Available	No	No	No	No

West Virginia, cont.

Coverage Level	BRONZE 3800	SILVER 7000	STANDARD SILVER 5900	SILVER 3500 (Off Exchange only)
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$7,000 Family: \$14,000	Individual: \$5,900 Family: \$11,800	Individual: \$3,500 Family: \$7,000
In–Network Out–of–pocket Maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,450 Family: \$18,900	Individual: \$9,100 Family: \$18,200	Individual: \$9,350 Family: \$18,700
Primary Care Visit	\$65 copay	\$55 copay	\$40 copay	\$45 copay
Specialist Visit	\$65 copay	\$55 copay	\$80 copay	\$45 copay
Outpatient Mental Health/Substance Abuse Visits	\$65 copay	\$55 copay	\$40 copay	\$45 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$65 copay	\$55 copay	\$40 copay	\$45 copay
Diagnostic Test (Lab/X-ray)	Lab: \$65 copay X-ray: \$150 copay	\$75 copay	40% after deductible	\$75 copay
Urgent Care	\$100 copay	\$100 copay	\$60 copay	\$90 copay
Emergency Services	50% after deductible	\$750 after deductible	40% after deductible	40% after deductible
Hospital Inpatient (per visit)	50% after deductible	\$1,125 after deductible	40% after deductible	40% after deductible
Pharmacy Summary	50%/50%/50%/50% after deductible	\$0/\$30/\$150/50%	\$20*/\$40*/\$80/\$350	\$0/\$50/\$225/50%
Adult Dental and Vision Available	Yes	No	Yes	Yes

West Virginia, cont.

Coverage Level	STANDARD GOLD 1500	GOLD 0	PREMIER GOLD 0	GOLD HSA 1700
Plan Availability	my Blue Access PPO			
In-Network Deductible	Individual: \$1,500 Family: \$3,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$1,700 Family: \$3,400
In–Network Out–of–pocket Maximum	Individual: \$8,700 Family: \$17,400	Individual: \$7,500 Family: \$15,000	Individual: \$6,700 Family: \$13,400	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$30 copay	\$20 copay	\$15 copay	\$20 after deductible
Specialist Visit	\$60 copay	\$20 copay	\$15 copay	\$20 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$30 copay	\$20 copay	\$15 copay	\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 copay	\$20 copay	\$15 copay	\$20 after deductible
Diagnostic Test (Lab/X-ray)	25% after deductible	\$35 copay	\$65 copay	\$20 after deductible
Urgent Care	\$45 copay	\$40 copay	\$30 copay	\$40 after deductible
Emergency Services	25% after deductible	\$300 copay	\$280 copay	\$175 after deductible
Hospital Inpatient (per visit)	25% after deductible	\$725 copay	\$525 copay	\$450 after deductible
Pharmacy Summary	\$15*/\$30*/\$60*/\$250*	\$0/\$30/\$150/50%	\$0/\$25/\$75/50%	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	No	Yes	Yes	No

^{*}Not subject to deductible

West Virginia — Extra Savings

Income Level	200-249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	STANDARD SILVER 5700	SILVER 0	STANDARD SILVER 700
Plan Availability	my Blue Access WV PPO	my Blue Access WV PPO	my Blue Access WV PPO	my Blue Access WV PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$5,700 Family: \$11,400	Individual: \$0 Family: \$0	Individual: \$700 Family: \$1,400
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,000 Family: \$6,000
Primary Care Visit	\$55 copay	\$40 copay	\$15 copay	\$20 copay
Specialist Visit	\$55 copay	\$80 copay	\$15 copay	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$55 copay	\$40 copay	\$15 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$55 copay	\$40 copay	\$15 copay	\$20 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	40% after deductible	\$25 copay	30% after deductible
Urgent Care	\$100 copay	\$60 copay	\$30 copay	\$30 copay
Emergency Services	\$750 after deductible	40% after deductible	\$275 copay	30% after deductible
Hospital Inpatient (per visit)	\$1,125 after deductible	40% after deductible	\$450 copay	30% after deductible
Pharmacy Summary	\$0/\$30/\$150/50%	\$20*/\$40*/\$80/\$350	\$0/\$10/\$50/50%	\$10*/\$20*/\$60/\$250
Adult Dental and Vision Available	No	Yes	No	Yes

^{*}Not subject to deductible

West Virginia — Extra Savings, cont.

Income Level	138–149% FPL			
Coverage Level	SILVER 0	STANDARD SILVER 0		
Plan Availability	my Blue Access WV PPO	my Blue Access WV PPO		
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0		
In–Network Out–of–pocket Maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,800 Family: \$3,600		
Primary Care Visit	\$1 copay	\$0 copay		
Specialist Visit	\$1 copay	\$10 copay		
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay		
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay		
Diagnostic Test (Lab/X-ray)	\$1 copay	25% coinsurance		
Urgent Care	\$5 copay	\$5 copay		
Emergency Services	\$75 copay	25% coinsurance		
Hospital Inpatient (per visit)	\$175 copay	25% coinsurance		
Pharmacy Summary	\$0/\$5/\$15/50%	\$0*/\$15*/\$50*/\$150*		
Adult Dental and Vision Available	No	Yes		

^{*}Not subject to deductible

Delaware

Coverage Level	MAJOR EVENTS 3 Free PCP Visits	BRONZE 8900	STANDARD BRONZE 7500	BRONZE HSA 7100 Custom Drug Benefit
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$7,500 Family: \$15,000	Individual: \$7,100 Family: \$14,200
In-Network Out-of-pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$8,900 Family: \$17,800	Individual: \$9,400 Family: \$18,800	Individual: \$7,100 Family: \$14,200
Primary Care Visit	\$0 after deductible; First three visits \$0 (not subject to deductible)	\$0 after deductible	\$50 copay	\$0 after deductible
Specialist Visit	\$0 after deductible	\$0 after deductible	\$100 copay	\$0 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$0 after deductible	\$50 copay	\$0 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$0 after deductible	Speech: \$50 copay All others: \$17 copay	\$0 after deductible
Diagnostic Test (Lab/X-ray)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Urgent Care	\$0 after deductible	\$0 after deductible	\$75 copay	\$0 after deductible
Emergency Services	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Hospital Inpatient (per visit)	\$0 after deductible	\$0 after deductible	50% after deductible	\$0 after deductible
Pharmacy Summary	\$0/\$0/\$0 after deductible	\$0/\$0/\$0/\$0 after deductible	\$25*/\$50/\$100/\$150 after deductible	\$0/\$0/\$0/\$0 after deductible
Adult Dental and Vision Available	No	No	No	No

^{*}Not subject to deductible

Delaware, cont.

Coverage Level	BRONZE 3800	SILVER 7000	STANDARD SILVER 5900	SILVER 3500 (Off Exchange only)
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,800 Family: \$7,600	Individual: \$7,000 Family: \$14,000	Individual: \$5,900 Family: \$11,800	Individual: \$3,500 Family: \$7,000
In-Network Out-of-pocket Maximum	Individual: \$9,200 Family: \$18,400	Individual: \$9,450 Family: \$18,900	Individual: \$9,100 Family: \$18,200	Individual: \$9,350 Family: \$18,700
Primary Care Visit	\$75 copay	\$75 copay	\$40 copay	\$55 copay
Specialist Visit	\$75 copay	\$75 copay	\$80 copay	\$55 copay
Outpatient Mental Health/Substance Abuse Visits	\$75 copay	\$75 copay	\$40 copay	\$55 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$17 copay	\$17 copay	Speech: \$40 copay All others: \$17 copay	\$17 copay
Diagnostic Test (Lab/X-ray)	Lab: \$65 copay X-ray: \$150 copay	\$75 copay	40% after deductible	\$75 copay
Urgent Care	\$100 copay	\$100 copay	\$60 copay	\$100 copay
Emergency Services	50% after deductible	\$750 after deductible	40% after deductible	40% after deductible
Hospital Inpatient (per visit)	50% after deductible	\$1,125 after deductible	40% after deductible	40% after deductible
Pharmacy Summary	50%/50%/50%/50% after deductible	\$0/\$30/\$150/50%	\$20*/\$40*/\$80/\$125	\$0/\$50/\$225/50%
Adult Dental and Vision Available	Yes	No	Yes	Yes

^{*}Not subject to deductible

Delaware, cont.

Coverage Level	STANDARD GOLD 1500	GOLD 0	PREMIER GOLD 0	GOLD HSA 1700
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$1,500 Family: \$3,000	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$1,700 Family: \$3,400
In-Network Out-of-pocket Maximum	Individual: \$8,700 Family: \$17,400	Individual: \$7,500 Family: \$15,000	Individual: \$6,700 Family: \$13,400	Individual: \$5,700 Family: \$11,400
Primary Care Visit	\$30 copay	\$20 copay	\$15 copay	\$20 after deductible
Specialist Visit	\$60 copay	\$20 copay	\$15 copay	\$20 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$30 copay	\$20 copay	\$15 copay	\$20 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	Speech: \$30 copay All others: \$17 copay	\$17 copay	\$15 copay	\$17 after deductible
Diagnostic Test (Lab/X-ray)	25% after deductible	\$35 copay	\$65 copay	\$20 after deductible
Urgent Care	\$45 copay	\$40 copay	\$30 copay	\$40 after deductible
Emergency Services	25% after deductible	\$300 copay	\$280 copay	\$175 after deductible
Hospital Inpatient (per visit)	25% after deductible	\$725 copay	\$525 copay	\$450 after deductible
Pharmacy Summary	\$15*/\$30*/\$60*/\$100*	\$0/\$30/\$150/50%	\$0/\$25/\$75/50%	\$0/\$30/\$150/50% after deductible
Adult Dental and Vision Available	No	Yes	Yes	No

^{*}Not subject to deductible

Delaware, cont.

Coverage Level	STANDARD PLATINUM 0	PLATINUM 0
Plan Availability	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$3,200 Family: \$6,400	Individual: \$5,000 Family: \$10,000
Primary Care Visit	\$10 copay	\$5 copay
Specialist Visit	\$20 copay	\$5 copay
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$5 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$10 copay	\$5 copay
Diagnostic Test (Lab/X-ray)	\$30 copay	\$10 copay
Urgent Care	\$15 copay	\$10 copay
Emergency Services	\$100 copay	\$100 copay
Hospital Inpatient (per visit)	\$360 copay	\$325 copay
Pharmacy Summary	\$5*/\$10*/\$50*/\$75	\$0/\$10/\$50/50%
Adult Dental and Vision Available	No	Yes

^{*}Not subject to deductible

Delaware — Extra Savings

Income Level	200-249% FPL		150-199% FPL	
Coverage Level	SILVER 3700	STANDARD SILVER 5700	SILVER 0	STANDARD SILVER 700
Plan Availability	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO	my Blue Access PPO
In-Network Deductible	Individual: \$3,700 Family: \$7,400	Individual: \$5,700 Family: \$11,400	Individual: \$0 Family: \$0	Individual: \$700 Family: \$1,400
In-Network Out-of-pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,200 Family: \$14,400	Individual: \$3,150 Family: \$6,300	Individual: \$3,000 Family: \$6,000
Primary Care Visit	\$75 copay	\$40 copay	\$15 copay	\$20 copay
Specialist Visit	\$75 copay	\$80 copay	\$15 copay	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$75 copay	\$40 copay	\$15 copay	\$20 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$17 copay	Speech: \$40 copay All others: \$17 copay	\$15 copay	Speech: \$20 copay All others: \$17 copay
Diagnostic Test (Lab/X-ray)	\$65 copay	40% after deductible	\$25 copay	30% after deductible
Urgent Care	\$100 copay	\$60 copay	\$30 copay	\$30 copay
Emergency Services	\$750 after deductible	40% after deductible	\$275 copay	30% after deductible
Hospital Inpatient (per visit)	\$1,125 after deductible	40% after deductible	\$450 copay	30% after deductible
Pharmacy Summary	\$0/\$30/\$150/50%	\$20*/\$40*/\$80/\$125	\$0/\$10/\$50/50%	\$10*/\$20*/\$60/\$100
Adult Dental and Vision Available	No	Yes	No	Yes

^{*}Not subject to deductible

Delaware — Extra Savings, cont.

Income Level	138–149% FPL		
Coverage Level	SILVER 0	STANDARD SILVER 0	
Plan Availability	my Blue Access PPO	my Blue Access PPO	
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	
In–Network Out–of–pocket Maximum	Individual: \$1,200 Family: \$2,400	Individual: \$1,900 Family: \$3,800	
Primary Care Visit	\$1 copay	\$0 copay	
Specialist Visit	\$1 copay	\$10 copay	
Outpatient Mental Health/Substance Abuse Visits	\$1 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$1 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$1 copay	25% coinsurance	
Urgent Care	\$5 copay	\$5 copay	
Emergency Services	\$75 copay	25% coinsurance	
Hospital Inpatient (per visit)	\$175 copay	25% coinsurance	
Pharmacy Summary	\$0/\$5/\$15/50%	\$0*/\$5*/\$10*/\$20*	
Adult Dental and Vision Available	No	Yes	

^{*}Not subject to deductible

Western New York

Coverage Level	BRONZE STANDARD HSAQ	BRONZE POS 8000	SILVER STANDARD	SILVER POS 7000 HSAQ
Plan Availability	POS	POS	POS	POS
In-Network Deductible	Individual: \$6,100 Family: \$12,200	Individual: \$8,500 Family: \$17,000	Individual: \$2,100 Family: \$4,200	Individual: \$3,000 Family: \$6,000
In–Network Out–of–pocket Maximum	Individual: \$7,150 Family: \$14,300	Individual: \$9,100 Family: \$18,200	Individual: \$9,450 Family: \$18,900	Individual: \$7,000 Family: \$14,000
Primary Care Visit	50% after deductible	50% after deductible	\$30 after deductible One \$0 pre-deductible office visit	\$30 after deductible
Specialist Visit	50% after deductible	50% after deductible	\$65 after deductible	\$50 after deductible
Outpatient Mental Health/Substance Abuse Visits	50% after deductible	50% after deductible	\$30 after deductible	\$30 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	50% after deductible	50% after deductible	\$30 after deductible	\$30 after deductible
Diagnostic Test (Lab/X-ray)	50% after deductible	50% after deductible	\$50/\$75 after deductible	\$50 after deductible
Urgent Care	50% after deductible	50% after deductible	\$70 after deductible	\$75 after deductible
Emergency Services	50% after deductible	50% after deductible	\$500 after deductible	\$300 after deductible
Hospital Inpatient (per visit)	50% after deductible	50% after deductible	\$1,500 after deductible	\$1,000 after deductible
Pharmacy Summary	\$10/\$35/\$70 after deductible	\$15/50%/50% after deductible	\$15/\$40/\$75	\$5/\$50/50% after deductible
Adult Dental and Vision Available	No	Yes	No	No

Western New York, cont.

Coverage Level	SILVER DESTINATION 65	GOLD STANDARD	GOLD POS 200 HSAQ	GOLD DESTINATION 65
Plan Availability	POS	POS	POS	POS
In-Network Deductible	Individual: \$2,500 Family: \$5,000	Individual: \$600 Family: \$1,200	Individual: \$1,700 Family: \$3,400	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$5,900 Family: \$11,800	Individual: \$5,700 Family: \$11,400	Individual: \$9,450 Family: \$18,900
Primary Care Visit	\$0 after deductible	\$25 after deductible	\$20 after deductible	\$0 copay
Specialist Visit	\$35 after deductible	\$40 after deductible	\$40 after deductible	\$30 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 after deductible	\$25 after deductible	\$20 after deductible	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 after deductible	\$30 after deductible	\$20 after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	\$0/\$125 after deductible	\$40 after deductible	\$40 after deductible	\$30/\$125 copay
Urgent Care	\$60 after deductible	\$60 after deductible	\$50 after deductible	\$60 copay
Emergency Services	\$300 after deductible	\$150 after deductible	\$300 after deductible	\$300 copay
Hospital Inpatient (per visit)	\$750 after deductible	\$1,000 after deductible	\$750 after deductible	\$750 copay
Pharmacy Summary	\$15/\$50/50%	\$10/\$35/\$70	\$5/\$40/50% after deductible	\$5/\$50/50%
Adult Dental and Vision Available	No	No	No	No

Western New York, cont.

Coverage Level	PLATINUM STANDARD	PLATINUM POS PLUS
Plan Availability	POS	POS
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$2,000 Family: \$4,000	Individual: \$6,500 Family: \$13,000
Primary Care Visit	\$15 copay	\$10 copay
Specialist Visit	\$35 copay	\$30 copay
Outpatient Mental Health/Substance Abuse Visits	\$15 copay	\$10 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$25 copay	\$10 copay
Diagnostic Test (Lab/X-ray)	\$35 copay	\$30 copay
Urgent Care	\$55 copay	\$40 copay
Emergency Services	\$100 copay	\$300 copay
Hospital Inpatient (per visit)	\$500 copay	\$500 copay
Pharmacy Summary	\$10/\$30/\$60	\$5/\$30/50%
Adult Dental and Vision Available	No	Yes

Western New York — Extra Savings

Income Level	200-249% FPL		
Coverage Level	SILVER STANDARD A	SILVER POS 7000 HSAQ A	SILVER DESTINATION 65 A
Plan Availability	POS	POS	POS
In-Network Deductible	Individual: \$1,925 Family: \$3,850	Individual: \$2,100 Family: \$4,200	Individual: \$1,925 Family: \$3,850
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$6,500 Family: \$13,000	Individual: \$7,550 Family: \$15,100
Primary Care Visit	\$30 after deductible One \$0 copay is available on any type of office visit	\$30 after deductible	\$0 after deductible
Specialist Visit	\$65 after deductible	\$50 after deductible	\$35 after deductible
Outpatient Mental Health/Substance Abuse Visits	\$30 after deductible	\$30 after deductible	\$0 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 after deductible	\$30 after deductible	\$0 after deductible
Diagnostic Test (Lab/X-ray)	\$50/\$75 after deductible	\$50 after deductible	\$0/\$125 after deductible
Urgent Care	\$70 after deductible	\$75 after deductible	\$60 after deductible
Emergency Services	\$275 after deductible	\$300 after deductible	\$300 after deductible
Hospital Inpatient (per visit)	\$1,500 after deductible	\$1,000 after deductible	\$750 after deductible
Pharmacy Summary	\$15/\$40/\$75	\$5/\$50/50% after deductible	\$15/\$50/50%
Adult Dental and Vision Available	No	No	No

Western New York — Extra Savings, cont.

Income Level	150-199% FPL				
Coverage Level	SILVER STANDARD B	SILVER POS 7000 B	SILVER DESTINATION 65 B		
Plan Availability	POS	POS	POS		
In-Network Deductible	Individual: \$275 Family: \$550	Individual: \$800 Family: \$1,600	Individual: \$0 Family: \$0		
In-Network Out-of-pocket Maximum	Individual: \$3,150 Family: \$6,300	Individual: \$1,800 Family: \$3,600	Individual: \$3,150 Family: \$6,300		
Primary Care Visit	\$15 after deductible One \$0 copay is available on any type of office visit	\$30 after deductible	\$0 copay		
Specialist Visit	\$35 after deductible	\$50 after deductible	\$35 copay		
Outpatient Mental Health/Substance Abuse Visits	\$15 after deductible	\$30 after deductible	\$0 copay		
Speech, Physical, and Occupational Therapy/Chiropractic	\$25 after deductible	\$30 after deductible	\$0 copay		
Diagnostic Test (Lab/X-ray)	\$35 after deductible	\$50 after deductible	\$0/\$125 copay		
Urgent Care	\$50 after deductible	\$75 after deductible	\$60 copay		
Emergency Services	\$75 after deductible	\$300 after deductible	\$300 copay		
Hospital Inpatient (per visit)	\$250 after deductible	\$1,000 after deductible	\$750 copay		
Pharmacy Summary	\$9/\$20/\$40	\$5/\$50/50% after deductible	\$15/\$50/50%		
Adult Dental and Vision Available	No	No	No		

Western New York — Extra Savings, cont.

Income Level	138–149% FPL			
Coverage Level	SILVER STANDARD C	SILVER POS 7000 C	SILVER DESTINATION 65 C	
Plan Availability	POS	POS	POS	
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	
In–Network Out–of–pocket Maximum	Individual: \$1,000 Family: \$2,000	Individual: \$700 Family: \$1,400	Individual: \$750 Family: \$1,500	
Primary Care Visit	\$10 copay	\$30 copay	\$0 copay	
Specialist Visit	\$20 copay	\$50 copay	\$35 copay	
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$30 copay	\$0 copay	
Speech, Physical, and Occupational Therapy/Chiropractic	\$15 copay	\$30 copay	\$0 copay	
Diagnostic Test (Lab/X-ray)	\$20 copay	\$50 copay	\$0/\$125 copay	
Urgent Care	\$30 copay	\$75 copay	\$60 copay	
Emergency Services	\$50 copay	\$300 copay	\$300 copay	
Hospital Inpatient (per visit)	\$100 copay	\$1,000 copay	\$750 copay	
Pharmacy Summary	\$6/\$15/\$30	\$5/\$50/50%	\$15/\$50/50%	
Adult Dental and Vision Available	No	No	No	

Northeastern New York

Coverage Level	BRONZE STANDARD HSAQ	SILVER STANDARD	SILVER DESTINATION 65	GOLD STANDARD
Plan Availability	POS	POS	POS	POS
In-Network Deductible	Individual: \$6,100 Family: \$12,200	Individual: \$2,100 Family: \$4,200	Individual: \$2,500 Family: \$5,000	Individual: \$600 Family: \$1,200
In–Network Out–of–pocket Maximum	Individual: \$7,150 Family: \$14,300	Individual: \$9,450 Family: \$18,900	Individual: \$9,450 Family: \$18,900	Individual: \$5,900 Family: \$11,800
Primary Care Visit	50% after deductible	\$30 after deductible One \$0 copay is allowed for any type of office visit	\$0 after deductible	\$25 after deductible
Specialist Visit	50% after deductible	\$65 after deductible	\$40 after deductible	\$40 after deductible
Outpatient Mental Health/Substance Abuse Visits	50% after deductible	\$30 after deductible	\$0 after deductible	\$25 after deductible
Speech, Physical, and Occupational Therapy/Chiropractic	50% after deductible	\$30 after deductible	\$0 after deductible	\$30 after deductible
Diagnostic Test (Lab/X-ray)	50% after deductible	\$50/\$75 after deductible	\$0/\$125 after deductible	\$40 after deductible
Urgent Care	50% after deductible	\$70 after deductible	\$60 after deductible	\$60 after deductible
Emergency Services	50% after deductible	\$500 after deductible	\$300 after deductible	\$150 after deductible
Hospital Inpatient (per visit)	50% after deductible	\$1,500 after deductible	\$750 after deductible	\$1,000 after deductible
Pharmacy Summary	\$10/\$35/\$70 after deductible	\$15/\$40/\$75	\$15/\$50/50%	\$10/\$35/\$70
Adult Dental and Vision Available	No	No	Yes	No

Northeastern New York, cont.

Coverage Level	GOLD DESTINATION 65	PLATINUM STANDARD
Plan Availability	POS	POS
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$9,450 Family: \$18,900	Individual: \$2,000 Family: \$4,000
Primary Care Visit	\$0 copay	\$15 copay
Specialist Visit	\$35 copay	\$35 copay
Outpatient Mental Health/Substance Abuse Visits	\$0 copay	\$15 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$0 copay	\$25 copay
Diagnostic Test (Lab/X-ray)	\$0/\$125 copay	\$35 copay
Urgent Care	\$60 copay	\$55 copay
Emergency Services	\$300 copay	\$100 copay
Hospital Inpatient (per visit)	\$750 copay	\$500 copay
Pharmacy Summary	\$5/\$50/50%	\$10/\$30/\$60
Adult Dental and Vision Available	Yes	No

Northeastern New York — Extra Savings

Income Level	200–249% FPL		150–199% FPL	
Coverage Level	SILVER STANDARD A	SILVER DESTINATION 65 A	SILVER STANDARD B	SILVER DESTINATION 65 B
Plan Availability	POS	POS	POS	POS
In-Network Deductible	Individual: \$1,925 Family: \$3,850	Individual: \$2,000 Family: \$4,000	Individual: \$275 Family: \$550	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$7,550 Family: \$15,100	Individual: \$7,550 Family: \$15,100	Individual: \$3,150 Family: \$6,300	Individual: \$3,150 Family: \$6,300
Primary Care Visit	\$30 after deductible One \$0 copay is allowed for any type of office visit	\$0 after deductible	\$15 after deductible One \$0 copay is allowed for any type of office visit	\$0 copay
Specialist Visit	\$65 after deductible	\$40 after deductible	\$35 after deductible	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$30 after deductible	\$0 after deductible	\$15 after deductible	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$30 after deductible	\$0 after deductible	\$25 after deductible	\$0 copay
Diagnostic Test (Lab/X-ray)	\$50/\$75 after deductible	\$0/\$125 after deductible	\$35 after deductible	\$0/\$125 copay
Urgent Care	\$70 after deductible	\$60 after deductible	\$50 after deductible	\$60 copay
Emergency Services	\$275 after deductible	\$300 after deductible	\$75 after deductible	\$300 copay
Hospital Inpatient (per visit)	\$1,500 after deductible	\$750 after deductible	\$250 after deductible	\$750 copay
Pharmacy Summary	\$15/\$40/\$75	\$15/\$50/50%	\$9/\$20/\$40	\$15/\$50/50%
Adult Dental and Vision Available	No	Yes	No	Yes

Northeastern New York — Extra Savings, cont.

Income Level	138-149% FPL	
Coverage Level	SILVER STANDARD C	SILVER DESTINATION 65 C
Plan Availability	POS	POS
In-Network Deductible	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0
In–Network Out–of–pocket Maximum	Individual: \$1,000 Family: \$2,000	Individual: \$750 Family: \$1,500
Primary Care Visit	\$10 copay	\$0 copay
Specialist Visit	\$20 copay	\$40 copay
Outpatient Mental Health/Substance Abuse Visits	\$10 copay	\$0 copay
Speech, Physical, and Occupational Therapy/Chiropractic	\$15 copay	\$0 copay
Diagnostic Test (Lab/X-ray)	\$20 copay	\$0/\$125 copay
Urgent Care	\$30 copay	\$60 copay
Emergency Services	\$50 copay	\$300 copay
Hospital Inpatient (per visit)	\$100 copay	\$750 copay
Pharmacy Summary	\$6/\$15/\$30	\$15/\$50/50%
Adult Dental and Vision Available	No	Yes

Pennsylvania — Together Blue EPO

Facility Name	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	Allegheny	
AHN West Penn Hospital		
AHN Wexford Hospital	1	
The Children's Home of Pittsburgh		
The Children's Institute of Pittsburgh		
UPMC Children's Hospital of Pittsburgh		
UPMC Western Psychiatric Hospital		
UPMC Bedford Memorial	Bedford	
UPMC Altoona	Blair	
AHN Westfield Memorial Hospital	Chautauqua (New York)	
AHN Saint Vincent Hospital	Erie	
UPMC Jameson Hospital	Lawrence	
UPMC Kane Community Hospital	Mckean	
AHN Grove City Medical Center		
UPMC Horizon — Greenville	Mercer	
UPMC Horizon — Shenango Valley		
UPMC Cole	Potter	
UPMC Somerset Hospital	Somerset	
UPMC Northwest	Venango	
AHN Canonsburg Hospital	Washington	
AHN Hempfield Neighborhood Hospital	Westmoreland	

Pennsylvania my Direct Blue EPO

Facility Name	County	
WellSpan Gettysburg Hospital	Adams	
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	Allegheny	
Curahealth Pittsburgh		
Heritage Valley Kennedy		
Heritage Valley Sewickley		
St. Clair Hospital		
The Children's Home of Pittsburgh		
The Children's Institute of Pittsburgh		
UPMC Children's Hospital of Pittsburgh		
UPMC Western Psychiatric Hospital		
Armstrong County Memorial Hospital	Armstrong	
Curahealth Hospital Heritage Valley	Begver	
Heritage Valley Beaver	beuver	
UPMC Bedford	Bedford	
Penn State Health St. Joseph Medical Center	Berks	
Surgical Institute of Reading	Derks	
Conemaugh Nason Medical Center		
Penn Highlands Tyrone	Blair	
UPMC Altoona		
Guthrie Robert Packer Hospital		
Guthrie Towanda Memorial Hospital	Bradford	
Guthrie Troy Community Hospital		
Doylestown Hospital		
Grand View Hospital	Bucks	
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	Cumbria	
Select Specialty Hospital — Johnstown		
St. Luke's Hospital — Carbon Campus	Carbon	
St. Luke's Hospital — Leighton Campus		
Mount Nittany Medical Center	Centre	
Main Line Health — Bryn Mawr Rehab Hospital		
Main Line Health — Paoli Hospital Chester		
Penn Medicine — Chester County Hospital		
BHS Clarion Hospital	Clarion	

Facility Name	County	
Bucktail Medical Center		
UPMC Lock Haven	Clinton	
Meadville Medical Center		
Titusville Area Hospital	Crawford	
Penn State Health Hampden Medical Center		
Penn State Health Holy Spirit Medical Center		
Select Specialty Hospital — Camp Hill	Cumberland	
UPMC Carlisle		
Penn State Health Children's Hospital — Milton S. Hershey Medical Center	Dauphin	
Penn State Health Milton S. Hershey Medical Center		
Crozer Health — Chester Medical Center		
Crozer Health — Delaware County Memorial Hospital		
Crozer Health — Springfield Hospital	Delaware	
Crozer Health — Taylor Hospital	1	
Main Line Health — Riddle Hospital	1	
AHN Saint Vincent Hospital		
LECOM Health — Corry Memorial Hospital		
LECOM Health — Millcreek Community Hospital	- Erie	
Select Specialty Hospital – Erie		
Penn Highlands Connellsville		
WVU Medicine — Uniontown Hospital	Fayette	
WellSpan Chambersburg Hospital	Franklin	
WellSpan Waynesboro Hospital	Franklin	
Washington Health System Greene	Greene	
CHS Moses Taylor Hospital		
CHS Regional Hospital of Scranton	Laskawana	
Geisinger Medical Center Muncy	- Lackawanna	
Geisinger Community Medical Center		
Lancaster General Hospital		
Lancaster General Hospital Women & Babies		
Lancaster Surgery Center	Lancaster	
Penn State Health Lancaster Medical Center		
WellSpan Ephrata Community Hospital		
Lawrence County Surgery Center of Edgewood Surgical Hospital	Lawrence	
UPMC Jameson		
WellSpan Good Samaritan Hospital	Lebanon	
Lehigh Valley Hospital — 17th Street		
Lehigh Valley Hospital — Cedar Crest	Lehigh	
Lehigh Valley Hospital — Coordinated Health Allentown		
Lehigh Valley Cedar Crest — Reilly Children's Hospital		
CHS First Hospital Wyoming Valley		
CHS Wilkes-Barre General Hospital	Luzerne	
Geisinger Wyoming Valley Medical Center	Luzerne	
Lehigh Valley Hospital — Hazleton		

Pennsylvania — my Direct Blue EPO, cont.

Facility Name	County	
Geisinger Jersey Shore Hospital		
UPMC Muncy	Lycoming	
UPMC Williamsport		
UPMC Williamsport Divine Providence		
Bradford Regional Medical Center		
UPMC Kane Community Hospital	McKean	
AHN Grove City Medical Center		
Edgewood Surgical Hospital		
Sharon Regional Medical Center	Mercer	
UPMC Horizon — Greenville		
UPMC Horizon — Shenango Valley		
Lehigh Valley Hospital — Pocono		
St. Luke's Hospital — Monroe Campus	Monroe	
Einstein Medical Center Elkins Park		
Einstein Medical Center Montgomery		
Holy Redeemer Hospital		
Jefferson Health — Abington Hospital	Montgomery	
Jefferson Health — Abington—Lansdale Hospital	Monigoniery	
Main Line Health — Bryn Mawr Hospital		
Main Line Health — Lankenau Medical Center		
Lehigh Valley Hospital — Coordinated Health Bethlehem	Nouthannaton	
Lehigh Valley Hospital – Hecktown Oaks Lehigh Valley Hospital — Muhlenberg	Northampton	
Children's Hospital of Philadelphia		
Einstein Medical Center Philadelphia		
Jefferson Health — Frankford Hospital		
Jefferson Health — Methodist Hospital		
Jefferson Health — Thomas Jefferson University Hospital		
Jefferson Health — Torresdale Hospital	Philadelphia	
Jefferson Health — WillsEye Hospital		
Penn Medicine — Hospital of the University of Pennsylvania		
Penn Medicine — Penn Presbyterian Medical Center		
Penn Medicine — Pennsylvania Hospital		
Temple Health — Fox Chase Cancer Center		
Temple Health — Temple University Hospital		
UPMC Cole	Potter	
Geisinger St. Luke's Hospital		
Lehigh Valley Hospital — Schuylkill E. Norwegian Street	Schuylkill	
Lehigh Valley Hospital — Schuylkill S. Jackson Street	•	
Chan Soon-Shiong Medical Center at Windber		
Conemaugh Meyersdale Medical Center	Somerset	
UPMC Somerset		
Barnes-Kasson Hospital		
Endless Mountains Health Systems	Susquehanna	
UPMC Wellsboro	Tioga	
Evangelical Community Hospital	Union	
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Facility Name	County	
UPMC Northwest	Venango	
Warren General Hospital	Warren	
Advanced Surgical Hospital		
AHN Canonsburg Hospital		
Monongahela Valley Hospital	Washington	
Washington Hospital		
Wayne Memorial Hospital	Wayne	
AHN Hempfield Neighborhood Hospital	Westmoreland	
Excela Health Frick Hospital		
Excela Health Latrobe Hospital		
Excela Health Westmoreland Hospital		
Select Specialty Hospital — Laurel Highlands		
CHS Tyler Memorial Hospital	Wyoming	
WellSpan York Hospital	York	
WellSpan Surgery and Rehabilitation Hospital		

Out of state providers

Facility Name	State	
Meritus Medical Center		
The Johns Hopkins Hospital		
University of Maryland Medical Center MD UPMC Western Maryland		
		WVU Medicine — Garrett Regional Medical Center
AHN Westfield Memorial Hospital		
Guthrie Corning Hospital		
Olean General Hospital	New York	
UR Medicine — Jones Memorial Hospital		
UR Medicine — Strong Memorial Hospital		
Cleveland Clinic	ОН	
WVU Medicine — Children's Hospital	2407	
WVU Medicine — J.W. Ruby Memorial Hospital	WV	

Pennsylvania my Blue Access PPO

Facility Name	County	
WellSpan Gettysburg Hospital	Adams	
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		
Curahealth Pittsburgh		
Heritage Valley Kennedy		
Heritage Valley Sewickley		
Select Specialty Hospital — McKeesport		
Select Specialty Hospital — Pittsburgh UPMC		
St. Clair Hospital	Allegheny	
The Children's Home of Pittsburgh		
The Children's Institute of Pittsburgh		
UPMC Children's Hospital of Pittsburgh		
UPMC East		
UPMC Magee-Womens Hospital		
UPMC McKeesport		
UPMC Mercy		
UPMC Vision & 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	_	
Heritage Valley Beaver	Beaver	
UPMC Bedford Memorial	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		
BHS Butler Memorial Hospital	B	
UPMC Passavant — Cranberry	Butler	

Facility Name	County	
Conemaugh Memorial Medical Center	·	
Conemaugh Memorial Medical Center — Lee Campus		
Conemaugh Miners Medical Center	Cambria	
Select Specialty Hospital — Johnstown		
St. Luke's Hospital — Carbon Campus		
St. Luke's Hospital — Leighton Campus	Carbon	
Mount Nittany Medical Center	Centre	
Penn Medicine — Chester County Hospital	Chester	
BHS Clarion Hospital	Clarion	
Penn Highlands Clearfield		
Penn Highlands DuBois	Clearfield	
Bucktail Medical Center		
UPMC Lock Haven	Clinton	
CHS Berwick Hospital Center	Columbia	
Geisinger Bloomsburg Hospital		
Meadville Medical Center	Crawford	
Titusville Area Hospital		
Penn State Health Hampden Medical Center		
Penn State Health Holy Spirit Medical Center		
Select Specialty Hospital — Camp Hill	Cumberland	
UPMC Carlisle		
UPMC West Shore		
Penn State Health Children's Hospital		
Penn State Health Milton S. Hershey Medical Center	Dauphin	
UPMC Community Osteopathic	-	
UPMC Harrisburg		
Penn Highlands Elk	Elk	
AHN Saint Vincent Hospital		
LECOM Health — Corry Memorial Hospital		
LECOM Health — Millcreek Community Hospital	Erie	
Select Specialty Hospital – Erie		
UPMC Hamot		
Penn Highlands Connellsville	Fayette	
WVU Medicine — Uniontown Hospital	. 4,55	
WellSpan Chambersburg Hospital	Franklin	
WellSpan Waynesboro Hospital	Franklin	
Fulton County Medical Center	Fulton	
Washington Health System Greene	Greene	
Penn Highlands Huntingdon	Huntingdon	
Indiana Regional Medical Center	Indiana	
Penn Highlands Brookville	lefferson	
Punxsutawney Area Hospital	Jefferson	
CHS Moses Taylor Hospital		
CHS Regional Hospital of Scranton	Lasta	
Geisinger Community Medical Center Lackawanna		
Colonigor Community Miculation Common		

Pennsylvania — my Blue Access PPO, cont.

Facility Name	County	
Lancaster General Hospital		
Lancaster General Hospital Women and Babies		
Lancaster Surgery Center	Lancaster	
Penn State Health Lancaster Medical Center		
UPMC Lititz		
WellSpan Ephrata Community Hospital		
Lawrence County Surgery Center of Edgewood Surgical Hospital	Lawrence	
UPMC Jameson		
WellSpan Good Samaritan Hospital	Lebanon	
Lehigh Valley Hospital — 17th Street		
Lehigh Valley Hospital — Cedar Crest		
Lehigh Valley Hospital — Coordinated Health Allentown	t alicale	
Lehigh Valley Reilly Children's Hospital	Lehigh	
St. Luke's Hospital — Allentown Campus		
St. Luke's Hospital — Sacred Heart Campus		
CHS First Hospital Wyoming Valley		
CHS Wilkes-Barre General Hospital		
Geisinger Wyoming Valley Medical Center	Luzerne	
Lehigh Valley Hospital — Hazleton		
Geisinger Jersey Shore Hospital		
UPMC Muncy		
UPMC Williamsport	Lycoming	
UPMC Williamsport Divine Providence		
Bradford Regional Medical Center		
UPMC Kane	McKean	
AHN Grove City Hospital		
Edgewood Surgical Hospital		
Sharon Regional Medical Center	Mercer	
UPMC Horizon — Greenville		
UPMC Horizon — Shenango Valley		
Geisinger Lewistown Hospital	Mifflin	
Lehigh Valley Hospital — Pocono		
St. Luke's Hospital — Monroe Campus	Monroe	
Geisinger Janet Weis Children's Hospital		
Geisinger Medical Center	Montour	
Lehigh Valley Hospital — Coordinated Health Bethlehem		
Lehigh Valley Hospital – Hecktown Oaks		
Lehigh Valley Hospital — Muhlenberg	N 11 1	
St. Luke's Hospital — Anderson Campus	Northampton	
St. Luke's Hospital — Easton Campus		
St. Luke's University Hospital — Bethlehem		
Geisinger Shamokin Area Community Hospital	Northumberland	

Facility Name	County	
Penn Medicine — Hospital of the University of Pennsylvania		
Penn Medicine — Penn Presbyterian Medical Center	Philadelphia	
Penn Medicine — Pennsylvania Hospital		
Temple Health — Fox Chase Cancer Center		
Temple Health — Temple University Hospital		
UPMC Cole	Potter	
Geisinger St. Luke's Hospital		
Lehigh Valley Hospital — Schuylkill E. Norwegian Street	0.1 11:11	
Lehigh Valley Hospital — Schuylkill S. Jackson Street	Schuylkill	
St. Luke's Hospital — Miners Campus		
Chan Soon-Shiong Medical Center at Windber		
Conemaugh Meyersdale Medical Center	Somerset	
UPMC Somerset		
Barnes-Kasson Hospital		
Endless Mountains Health Systems	Susquehanna	
UPMC Wellsboro	Tioga	
Evangelical Community Hospital	Union	
UPMC Northwest	Venango	
Warren General Hospital	Warren	
Advanced Surgical Hospital		
AHN Canonsburg Hospital	Washington	
Monongahela Valley Hospital		
Washington Hospital		
Wayne Memorial Hospital	Wayne	
AHN Hempfield Neighborhood Hospital		
Excela Health Frick Hospital		
Excela Health Latrobe Hospital	Westmoreland	
Excela Health Westmoreland Hospital		
Select Specialty Hospital — Laurel Highlands		
CHS Tyler Memorial Hospital	Wyoming	
OSS Orthopaedic Hospital		
UPMC Hanover		
UPMC Memorial	York	
WellSpan Surgery and Rehabilitation Hospital		
WellSpan York Hospital		

Pennsylvania — my Blue Access PPO, cont.

Out of state providers

Facility Name	State	
Meritus Medical Center		
The Johns Hopkins Hospital		
University of Maryland Medical Center	MD	
UPMC Western Maryland		
WVU Medicine — Garrett Regional Medical Center		
AHN Westfield Memorial Hospital		
Guthrie Corning Hospital		
Olean General Hospital	New York	
UR Medicine — Jones Memorial Hospital		
UR Medicine — Strong Memorial Hospital		
Cleveland Clinic	ОН	
WVU Medicine — Children's Hospital	2404	
WVU Medicine — J.W. Ruby Memorial Hospital	– wv	

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 Blue Card.

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	B 1	
Weirton Medical Center	Brooke	
Cabell Huntington Hospital		
River Park Hospital	Cabell	
St. Mary's Medical Center		
Minnie Hamilton Health Center	Calhoun	
Montgomery General Hospital		
Plateau Medical Center	Fayette	
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		
WVU Medicine — Highland—Clarksburg Hospital	Harrison	
WVU Medicine — Jackson General Hospital	Jackson	
WVU Medicine — Jefferson Medical Center	Jefferson	
CAMC Womens and Children		
CAMA General Hospital	Kanawha	
CAMA Memorial Hospital		
Saint Francis Hospital		
Select Specialty Hospital — Charleston		
Thomas Memorial Hospital		
Stonewall Jackson Memorial Hospital	Lewis	
Logan General Hospital	Logan	
WVU Medicine – Fairmont Medical Center	Marion	
WVU Medicine — Reynolds Memorial Hospital	Marshall	
Pleasant Valley Hospital	Mason	
Welch Community Hospital	McDowell	
WVU Medicine — Princeton Community Hospital	Mercer	
WVU Medicine — Potomac Valley Hospital	Mineral	
Mon Health Medical Center		
WVU Medicine — Chestnut Ridge Center	-	
WVU Medicine — Children's Hospital	Monongalia	
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		
WVU Medicine — Wheeling Hospital	Ohio	

Facility Name	County
Pocahontas Memorial Hospital	Pocahontas
Mon Health Preston Memorial Hospital	Preston
Charleston Area Medical Center Teays Valley Hospital	Putnam
Beckley ARH Hospital	5111
Raleigh General Hospital	Raleigh
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	
Pikeville Medical Center	KY
Tug Valley ARH Regional Medical Center	KI .
University of Kentucky HealthCare Hospitals	
Meritus Medical Center	
The Johns Hopkins Hospital	
University of Maryland Medical Center	MD
UPMC Western Maryland	
WVU Medicine — Garrett Regional Medical Center	
Cleveland Clinic	
East Liverpool City Hospital	
Holzer Medical Center — Gallipolis	
Holzer Medical Center — Jackson	
Marietta Memorial Hospital	
Mount Carmel New Albany Surgical Hospital	
Selby General Hospital	ОН
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	

Delaware — my Blue Access PPO

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

Out of state providers

Facilty Name	State
The Johns Hopkins Hospital	MD
TidalHealth — Peninsula Regional Medical Center	MD
Memorial Sloan Kettering Cancer Center — Basking Ridge	NJ
Children's Hospital of Philadelphia	
Einstein Medical Center Philadelphia	1
PA Penn Medicine — Hospital of the University of Pennsylvania	
Penn Medicine - Pennsylvania Hospital	

Northeastern New York

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

Western New York

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

Vision and Dental

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

For most products, one plan at each metal level 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:

- A free 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.
- Two free cleanings.

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, and it can be accessed through **highmarkblueshield.com**.

How to find a provider

Visit highmarkblueshield.com and select the Find a Doctor or Pharmacy tab followed by Find an Eye Care Provider.

Dental networks

United Concordia Advantage Provider Network

More than 65,000 unique dentists at over 248,000 access points nationwide.

How to find a provider

Visit **highmarkblueshield.com** and select the **Find a Doctor** or **Pharmacy** tab.

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.

SECTION V: ACA INDIVIDUAL MARKET

Additional Resources

Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR)

Pennsylvania, West Virginia, and Delaware

What is the income for those covered under health plan?					
Who needs	Eligible for Medicaid	Eligible for CSRs and APTCs			Eligible for APTCs
coverage?	Medicaid	Silver Extra Savings Plans			Standard
	Eligible Range (100-138% or less FPL)	138–149% CSR plans	150–199% CSR plans	200–249% CSR plans	250%+FPL
Single	Less than \$20,120	\$20,121 – \$21,869	\$21,870 – \$29,159	\$29,160 - \$36,449	\$36,450 or more
Family of 2	Less than \$27,214	\$27,215 – \$29,579	\$29,580 - \$39,439	\$39,440 – \$49,299	\$49,300 or more
Family of 3	Less than \$34,307	\$34,308 – \$37,289	\$37,290 – \$49,719	\$49,720 – \$62,149	\$62,150 or more
Family of 4	Less than \$41,400	\$41,401 – \$44,999	\$45,000 – \$59,999	\$60,000 - \$74,999	\$75,000 or more
Family of 5	Less than \$48,493	\$48,494 – \$52,709	\$52,710 – \$70,279	\$70,280 - \$87,849	\$87,850 or more
Family of 6	Less than \$55,586	\$55,587 – \$60,419	\$60,420 - \$80,559	\$80,560 - \$100,699	\$100,700 or more
Family of 7	Less than \$62,680	\$62,681 – \$68,129	\$68,130 - \$90,839	\$90,840 - \$113,549	\$113,550 or more
Family of 8	Less than \$69,773	\$69,774 – \$75,839	\$75,840 – \$101,119	\$101,120 - \$126,399	\$126,400 or more

New York

Who needs	Eligible for Medicaid	Eligible for Essential Plans		Eligible for APTCs	
coverage?	100–138%	138%	250%	250% or more	
Single	Less than \$20,120	\$20,121	\$36,450	\$36,450 or more	
Family of 2	Less than \$27,214	\$27,215	\$49,300	\$49,300 or more	
Family of 3	Less than \$34,307	\$34,308	\$62,150	\$62,150 or more	
Family of 4	Less than \$41,400	\$41,401	\$75,000	\$75,000 or more	
Family of 5	Less than \$48,493	\$48,494	\$87,850	\$87,850 or more	
Family of 6	Less than \$55,586	\$55,587	\$100,700	\$100,700 or more	
Family of 7	Less than \$62,680	\$62,681	\$113,550	\$113,550 or more	
Family of 8	Less than \$69,773	\$69,774	\$126,400	\$126,400 or more	

Contribution and Out-of-Pocket Limits for QHDHPs and HSAs			
	2024	2023	Change
HSA contribution limit (employer + employee) HDHP minimum deductible	Self-only: \$4,150 Family: \$8,300 Self-only: \$1,600 Family: \$3,200	Self-only: \$3,850 Family: \$7,750 Self-only: \$1,500 Family: \$3,000	Self-only: +\$300 Family: +\$550 Self-only: +\$100 Family: +\$200
HDHP maximum out-of-pocket amounts (deductibles, copayments and other amounts, but no premiums)	Self-only: \$8,050 Family: \$16,100	Self-only: \$7,500 Family: \$15,000	Self-only: +\$550 Family: +\$1,100

 $[\]hbox{* For more information, visit ${\bf high mark spending accounts.com}.}$

The Department of Health and Human Services (HHS) establishes the annual out-of-pocket limits for essential health benefits covered under an ACA-compliant plan.

Take a look at these limits below:

	2024	2023
Out-of-pocket	Self-only:	Self-only:
limits for ACA-	\$9,450	\$9,100
compliant	Family:	Family:
plans (HHS)	\$18,900	\$18,200
Out-of-pocket	Self-only:	Self-only:
limits for	\$8,050	\$7,500
HSA-qualified	Family:	Family:
HDHPs (IRS)	\$16,100	\$15,000

Special Enrollment Period (SEP) Reminders

New SEP forms and applications are now available

Off-exchange SEP forms and applications are now electronically fillable and contain a digital signature option. You can download these materials on **producer.highmark.com**, under the **Resources** section as separate documents. Completed applications can be submitted via the following methods:

- Email: dp_applications@highmark.com (one application per email)
- Fax: 866-224-5403
- Mail: Use the address on the application

Loss of Minimal Essential Coverage

Examples include:

- Losing eligibility for employer-sponsored coverage due to job loss, reduction in hours, or employer no longer offering benefits or closes.
- Expiration of COBRA coverage or non-calendar year policy.
- Losing pregnancy related or medically needy coverage under Medicaid.
- · Losing eligibility for Medicaid or CHIP.
- Losing eligibility for Medicare.

Did you know...

Highmark pays commission on SEP enrollments for new contracts and renewals! To confirm your available commission amount, please contact the agency you write individual policies through.

Deadline: Application, SEP form, and documentation can be submitted up to 60 days in advance of the loss of coverage, but no later than 60 days since coverage was lost.

Effective date: The first day of the month following the receipt of required forms and documentation. Effective date cannot be prior to the loss of coverage.

Note: Voluntarily quitting other health insurance coverage, being terminated for not paying premiums or losing health insurance coverage that does not qualify as minimum essential coverage, are not considered a loss of qualifying coverage.

A conversion or HIPAA plan may be a good option if your client's policy terms prior to end of month

Please refer to the off-exchange application for more detail.

Agent Sales Checklist

Here's the info needed for each person who will be covered on a plan.	
	Date of birth
	Social Security number (or legal immigrant documents)
	Income documentation for all household members, even if they won't be covered by the plan (pay stubs, W–2 forms, or wage and tax statements)
	Current health insurance policy numbers (if applicable)
	Info on any health insurance a consumer or their family could get from their job

SECTION V: ACA INDIVIDUAL MARKET

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Individual Coverage Health Reimbursement Arrangement (ICHRA)

ICHRA overview

Background

In June 2019, the Departments of the Treasury, Labor, and Health & Human Services jointly published a final rule to expand the flexibility and use of health reimbursement arrangements (HRAs) and other account-based group health plans to provide Americans with additional options to obtain quality, affordable health care.

This rule permits employers to offer an "individual coverage HRA" (ICHRA) as an alternative to traditional group health plan coverage, subject to certain conditions. Among other medical care expenses, ICHRAs can be used to reimburse premiums for individual health insurance chosen by the employee, promoting employee and employer flexibility, while also maintaining the same tax-favored status for employer contributions towards a traditional group health plan.

Employers can offer employees an ICHRA instead of offering traditional job-based health coverage. An ICHRA reimburses employees for medical expenses, including monthly premiums and other out-of-pocket costs like copayments and deductibles for insurance policies purchased in the individual market.

Things to keep in mind

- An ICHRA is not traditional group coverage it is Individual coverage reimbursed by the employer group.
- Employers are required to provide the employee with an ICHRA Notice that establishes the 60-day SEP opportunity for the employee.
- Employees and any covered dependents are required to be enrolled in Individual coverage or Medicare Parts A and B, or Part C in order to be reimbursed.
- Employees cannot be given an option between an ICHRA and group coverage.
- Policies may be purchased through the Marketplace (not eligible for APTC) or Off-Exchange.

Classifications

Once an employer group decides to move forward with an ICHRA, they begin the process by classifying those employees who will qualify for the ICHRA. Employers must follow specific guidelines to ensure equitable access to this offering, including:

- Employers cannot offer employees in the same class a choice between group or ICHRA.
- All employees that fit that classification designation must be offered the ICHRA.

The following are the 11 employee classifications and brief descriptions of each:

- 1. Full-time (working at least 30 hours a week)
- 2. Part-time (working less than 30 hours a week)
- 3. Seasonal (hired on a short-term basis or for a season)
- CBA (part of a Collective Bargaining Agreement agreement between employer, employee and their union)
- 5. Waiting period (just joined an employer)
- 6. Rating area (employees located in different geographic locations but their primary site of employment is in the same rating area)
- Non-resident alien (non-resident aliens with no US based income; includes foreign employees working abroad)
- 8. Salaried
- 9. Non-salaried (hourly workers who do not receive a salary)
- Staffing firm (employees placed for temp assignments)
- 11. Combination (two or more of the above classes can be combined to create a new class)

ICHRA/QSEHRA Application Processes

Here are some important dates to keep in mind throughout the application process:

- Allow 14 days from the date of submission for the application to process and bill account information to populate.
- Applications should be submitted by the 15th of the month for effectuation of the first of the following month.
- Applications submitted after the requested effectuation date will result in effectuation of the first of the following month.

Tools for navigating enrollment

Producer Portal

OEP — Please visit page 8 for an overview and instructions for utilizing this tool during the ACA Open Enrollment Period.

SEP — Outside of the Open Enrollment Period, the Producer Portal is now a helpful resource for submitting ICHRA/QSEHRA SEP applications. Please keep in mind the following when utilizing this solution:

- This Producer Portal SEP process is only available for ICHRA/QSEHRA applications and requires upload of supporting documentation (SEP Form and ICHRA Employer Notice) in order to complete each submission.
- SEP Portal applications must be submitted on or before 11:59 p.m. on the 15th of the month for an effective date of the 1st of the following month. (Example: Applications submitted by 3/15/2023 will have the option of either a 4/1/2023 or 5/1/2023 effective date. Applications submitted on the portal between 3/16/2023 3/31/2023 will only have the option for a 5/1/2023 effective date). To ensure the following month's effective date for submissions after the 15th of the month, the paper application submission process must be utilized.

Paper Application (OEP/SEP)

Producer Managed eBill Payment
Administration (Broker, Third Party
Administrator, etc.): Submit one application per
contract per email (including SEP Form and ICHRA
Notice when applicable) to the following addresses:

To: dp_applications@highmark.com
Cc: ichra@highmark.com

Employee/Member Managed Payment Administration: Submit one application per contract per email (including SEP Form and ICHRA Notice when applicable):

to: dp_applications@highmark.com

Spreadsheet (OEP)

For more information on the availability of a spreadsheet process, please contact the ICHRA team at ichra@highmark.com.

Here's how to use the Producer Portal during SEP

Step 1: Login Page

- Go to producer.highmark.com.
- Enter Username and Password.
- Click Submit to login.

Step 2: Choose an Agency

• In the Individual box, select New Business.

Step 3: New Business — Plan Type

 For an ICHRA policy, select Off Exchange Plans.

Step 4: New Business — Off Exchange

• Select **Start Enrollment** to enter member information and submit an application.

Step 5: State and Agency Details

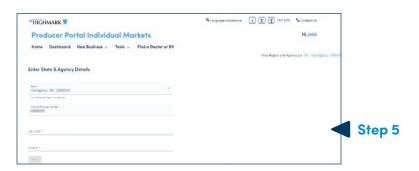
- Select the appropriate agency using the drop-down option in the Agency box (select the appropriate state if agency writes for multiple).
- Enter the Zip Code and ensure the correct County populates.
- Once all information is correct, the Next button will turn blue to proceed.











Step 6: Selecting the Special Event

Keep an eye out to ensure:

- The URL confirms selections made thus far.
- The correct Highmark branding for the application region should be reflected.
- The title Special Enrollment Events should be displayed for PA, WV, and DE.
- Select Yes under Do any of the life changes on this page apply to you?
- Once **Yes** is selected, a drop-down for Qualifying Life Event will populate.
- Using the drop-down, select either ICHRA or QSEHRA.
- Click Get A Quote at the bottom of the page.

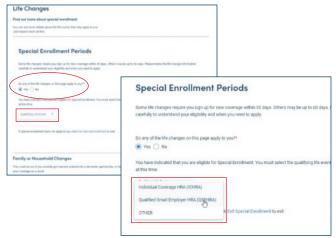
Step 7: Enter Member Specific Information

Utilize the drop-down box to select the Effective Date.

Note: Portal applications must be submitted on or before 11:59 p.m. on the 15th of the month for an effective date of the 1st of the following month. (Example: Applications submitted by 3/15/2023 have the option for either a 4/1/2023 or 5/1/2023 effective date. Applications submitted on the portal from 3/16/2023 – 3/31/2023 will only have the option for a 5/1/2023 effective.)

- Enter the member's Date of Birth.
- · Select the member's Gender.
- If the member uses tobacco, select the Tobacco Use box.
- Answer the final question of Are any members of you family eligible for Medicare? Then click Submit.







Step 7

Step 8: Select Plan

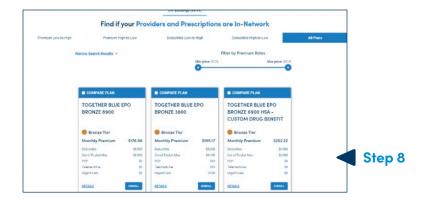
• Scroll through available plans.

Compare plans side by side by clicking the white square at the top left of the plan. Filter plans using the price toggle above plan boxes or by filtering by Premium, Deductible and all plans.

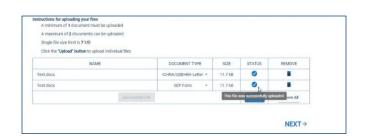
 Once the plan is selected, click the Enroll button at the bottom right of the plan box.

Step 9: SEP Document Upload

- The Effective Date of Coverage will be auto populated based on the selection made in Step 7.
- Download the SEP form by clicking on the **blue hyperlink**.
- You will not be able to proceed without downloading the SEP form, completing, and uploading along with the ICHRA Letter.
- Review the SEP form to ensure it is completed correctly and includes the required signatures (individual/spouse) before uploading.
- Follow instructions for uploading documents (separate documents is suggested).
- Select appropriate Document Type.
- Click **Upload** under the Status column to attach document.
- Once the blue check mark shows in the status box for each document, click Next.







Step 10: Member Details

• Process is Business as Usual (BAU).

Step 11: Health Insurance and Producer Information

Health Insurance Information

- Respond to the first three questions.
- Third Party Payer questions will prepopulate in grey based on your earlier application selections. No selection is necessary.
- Enter the Employers Name in the box (this is important for effective reconciliation and reporting).

Producer Information

 Double check that Producer information entered correctly into the boxes (this information should auto populate based off the login).

Step 12: Communication Preferences

 This portion of the application is BAU; consult Producer Portal portion of Doing Business with Highmark Federal Markets section.

Step 13: Application Summary

 This portion of the application is BAU; consult Producer Portal portion of Doing Business with Highmark Federal Markets section.



Step 14: Notifications and Authorizations

 This portion of the application is BAU; consult Producer Portal portion of Doing Business with Highmark Federal Markets section.

Step 15: Application Submission

 This portion of the application is BAU; consult Producer Portal portion of Doing Business with Highmark Federal Markets section.

ICHRA/QSEHRA eBill Payment Administration

Once an application has been submitted and processed, bill account information will generate an invoice for submission of the initial payment in order to effectuate the policy.

Highmark's eBill platform helps simplify the process whether the Producer (Broker, TPA) is managing payment administration, or the Employee is responsible for management of their own policy payments.

In either case, Highmark's eBill platform offers the ability to:

- Enter payment account information.
- Make an initial payment.
- Schedule recurring payments.
- · Receive notifications on payment status.

For more information on eBill setup and support options available, please refer to the respective contact information based on your ICHRA payment administration scenario outlined below:

Producer Managed eBill Payments

- Utilize unique eBill access after onboarding with ICHRA team.
- Work directly with ICHRA team for terminations and eBill support.
- For onboarding and Producer eBill support, reach out to ichra@highmark.com.

Employee Managed eBill Payments

- Utilize Member Portal access. Instructions are provided on page 15.
- Work directly with Member Service for assistance with billing and eBill support.
- For member setup or support inquiries, contact the Member Service number located on the back of the member ID card.

ICHRA Contact Information

- General ICHRA Inquiries, eBill Onboarding Requests, Producer eBill Support: ichra@highmark.com
- Producer Enrollment and Billing Inquiries: prodem@highmark.com
- ACA Producer Needs: ACAsalessupport@highmark.com
- ACA Commission Inquiries: ACAcompensation@highmark.com

Contact Information

Question	Market	Region Contact			
Application Status, Benefits, Claims, Prescriptions, and Provider Network Questions	Medicare	PA, WV, DE	800-652-9459 (Monday – Friday, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 1 prodem@highmark.com		
		WNY, NENY	844-946-6305 (Monday – Friday, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 1 albany.liaison@bsneny.com		
	ACA	PA, WV, DE	800-652-9459 (Monday – Friday, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 1 prodem@highmark.com		
		WNY, NENY	844-946-6305 (Monday – Friday, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 1 prodem@highmark.com		
	D-SNP	PA	888-871-0417 (Monday – Friday, 8 a.m. – 8 p.m., and Saturday and Sunday, 9 a.m. – 5 p.m. Closed Sundays, May – Sept.) agentspecialist@highmarkwholecare.com		
Onboarding, Training, and Producer Portal Questions	Medicare	PA, WV, DE, WNY, NENY	800-652-9459 (Monday – Friday, 8 a.m. – 4 p.m.) Option 1 (Senior Markets), then Option 2 highmarkseniormarkets@highmark.com		
Onboarding, Training, and Producer Portal Questions (continued)	ACA	PA, WV, DE, WNY, NENY	800-652-9459 (Monday – Friday, 8 a.m. – 4 p.m.) Option 2 (ACA), then Option 2 ACAsalessupport@highmark.com		
	D-SNP	PA	888–871–0417 (Monday – Friday, 8 a.m. – 8 p.m., and Saturday and Sunday, 9 a.m. – 5 p.m. Closed Sundays, May – Sept.) agentspecialist@highmarkwholecare.com		
Additional Highmark Wholecare Resources	D-SNP	PA	800-685-5209 highmarkwholecare.com/medicare		
Highmark Producer Portal	Medicare, ACA	PA, WV, DE, WNY, NENY	producer.highmark.com		

Question	Market	Region	Contact	
	Medicare, ACA	Western PA, Northeastern PA	highmarkbcbs.com	
		Central PA	highmarkblueshield.com	
Highmark		WV	highmarkbcbswv.com	
Consumer Websites		DE	highmarkbcbsde.com	
		WNY	bcbswny.com	
		NENY	bsneny.com	
	D-SNP	PA	highmarkwholecare.com	
Highmark Integrity Office	Medicare, ACA, D-SNP	PA, WV, DE, WNY, NENY	800-985-1056 integrity@highmark.com	
PA Exchange (Pennie)	ACA	PA	pennie.com 844-844-4440 brokers@pennie.com	
DE/WV Exchange	ACA	WV, DE	healthcare.gov 855-788-6275	
New York Exchange	ACA	WNY, NENY	nystateofhealth.ny.gov	
HealthSherpa	ACA	PA, WV, DE, WNY, NENY	888-684-1373 agent_support@healthsherpa.com	

Glossary

Applicable Law	Means any local, state and federal laws, statutes, regulations, rules, codes, ordinances, orders, decisions, licensing requirement, regulatory guidance, pronouncements, and instructions, declarations, decrees, directives, legislative enactments, other binding restrictions or requirements of or by any governmental authority, any interpretation of any of the foregoing by a governmental authority having jurisdiction or authority or any modified or supplemented version of the foregoing items, which applies to or affects the services provided or the other obligations of the parties hereunder. "Applicable Law" includes but is not limited to HIPAA, the regulations, guidance and instructions issued by CMS (including but not limited to the MMG), the Medicare Improvement for Patients and Providers Act, the False Claims Act (31 U.S.C. §§ 3729 et seq.), the anti-kickback statute (42 U.S.C. § 1320a–7b(b), Section 1557 of the Patient Protection and Affordable Care Act, TCPA and state and federal laws applicable to telemarketing, and laws or regulations applicable to insurers, agents and brokers.			
ВРМ	Broad Performance Medicare Network			
CMS	The Centers for Medicare and Medicaid Services. The federal agency who administers the Medicare Program.			
Field Agent Guide	A confidential and proprietary document developed exclusively for Highmark Field Agents.			
Highmark	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.			
НМО	Health Maintenance Organization			
Medicare	Health insurance provided by the U.S. government for people over 65, or for some disabled persons.			

MPVN	Medicare Preferred Value Network
PDP	Prescription Drug Plan (Part D)
PPO	Preferred Provider Plan
Producer Portal	The website you will use to enroll Medicare clients online, check the status of applications, order customized enrollment kits, request CMS approved marketing materials, view and download important documents, and view the most recent version of this Field Guide.
Ready to Sell	Trained, passed a background check, not on any exclusion lists, have an active state license, and have been appointed by Highmark to sell our products.
We and Us	Highmark
You and Yours	You, the reader

Enrollment/Disenrollment Member Responsibilities Quick Reference

Disenroll FROM	Enroll INTO	Member Responsibility		
Medicare Advantage		Member must have a valid election to disenroll from Medicare Advantage and must submit a disenrollment request, in writing, with a valid signature to their Medicare Advantage Plan in order to disenroll.		
	Medicare Supplement	 If the member is requesting to cancel their MA Plan before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service. Member can then be enrolled in Medigap once Proof of Prior Creditable Coverage documentation received. 		
		 If their MA Plan was also with Highmark and they now want to enroll in a Highmark Medigap Plan, a proof of prior coverage letter is not required, but we cannot move forward with a Medigap enrollment without an approved request to disenroll from their MA plan. 		
Medicare Advantage	Original Medicare	 Member must have a valid election to disenroll from Medicare Advantage and member must submit a disenrollment request, in writing, with a valid signature to the Medicare Advantage Plan in order to disenroll. 		
		 If attempting to cancel their MA Plan before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service. Once disenrolled from Medicare Advantage, the member will automatically be re-enrolled into Original Medicare. 		
	Medicare Advantage	 Member must have a valid election to enroll into Medicare Advantage and application must be received by the plan PRIOR to the effective date. 		
Medicare Supplement		 Member must submit a disenrollment request, in writing, with a valid signature. 		
		 If attempting to cancel Med Sup before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service. 		

Enrollment/Disenrollment Member Responsibilities Quick Reference, continued

Disenroll FROM	Enroll INTO	Member Responsibility		
Medicare Supplement	Original Medicare	Member must submit a disenrollment request, in writing, with a valid signature in order to disenroll.		
		 If the member is attempting to cancel their Med Sup before the effective date, a written request can be submitted OR a verbal request can be taken on a recorded line with Member Service; the member will then be placed back into Original Medicare. 		
Affordable Care Act (ACA) On-Exchange	Medicare Advantage	Member must disenroll via the Exchange (either Federal or Pennsylvania).		
		 Enrollment changes are received via file from the Exchanges. Member must have a valid election to enroll into Medicare Advantage. Application must be received by the plan PRIOR to the effective date. 		
Affordable Care Act (ACA) Off-Exchange	Medicare Advantage	 Member must have a valid election to enroll into Medicare Advantage and application must be received by the plan PRIOR to the effective date. 		
		 Member can call Member Service to disenroll from their off-exchange coverage or fill out a change form requesting the cancellation. 		
		Members will be disenrolled on the first of the following month after it is received OR the paid-to date.		
Affordable Care Act (ACA) On-Exchange	Medicare	Member must disenroll via the Exchange (either Federal or Pennsylvania)/Enrollment changes are received via file from the Exchanges.		
		Member can then be enrolled in Medigap once Proof of Prior Creditable Coverage documentation received from the applicant.		
	Supplement	If their Group Coverage was also with Highmark and they now want to enroll in a Highmark Medigap Plan, a letter is not required to show proof of prior coverage, but we cannot move forward with a Medigap enrollment without an end date to their group coverage appearing in Highmark's system.		

Disenroll FROM	Enroll INTO	Member Responsibility		
Group Health Care	ACA On- Exchange	 Member must notify their employer as to when their group coverage should end, and the new coverage will begin. Member has to enroll VIA the Exchanges (either Federal or Pennsylvania). 		
Group Health Care	ACA Off- Exchange	 Member must notify their employer as to when their group coverage should end, and the new coverage will begin. Member can enroll directly with Highmark. Outside of Open Enrollment Period, a valid SEP is needed, accompanied by all required documentation; effective date will be the first the following month. 		
Group Health Care	Medicare Advantage	Member must notify their employer as to when their group coverage should end, and the new coverage will begin.		
Group Health Care	Medicare Supplement	Member must notify their employer as to when their group coverage should end, and the new coverage will begin.		

Notes			

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:

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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.

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Sword Health, Inc. does not provide health care services. Sword Health, Inc. 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. The Sword virtual physical care program is made available with support from Sword Health.

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