2020 Community Blue Medicare HMO Summary of Benefits

Residents of the following counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland, **please click here.**

Residents of the following counties: Bedford, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Somerset, Venango and Warren **please click here.**

HIGHMARK

WESTERN PENNSYLVANIA

Community Blue Medicare HMO

Summary of Benefits

January 1, 2020 to December 31, 2020

The service area for these plans includes the following counties:

Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Community Blue Medicare HMO, call 1-866-687-3182 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week. Or visit medicare.highmark.com.

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This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Community Blue Medicare HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com.** Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

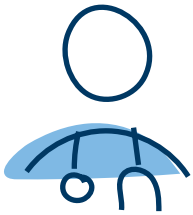
If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Blues On Call℠

Answers from a health pro, 24/7.

Travel Benefits (PPO)

Coverage that travels with you.



Telemedicine

Face-to-face with a doctor, 24/7.

Highmark House Call

Once-a-year in-home health review.

If you have questions as you go along, visit medicare.highmark.com.

Western Pennsylvania

	Community Blue Medicare HMO Signature
Premium	$0
Part B Premium Reduction	$3
Deductible	$0
Max Out-Of-Pocket	$6,700
Inpatient Hospital Stay*	$295 Copay Per Admit
Outpatient Hospital Coverage*	ASC[1]: $225 Copay Facility: $275 Copay
Doctor Office Visit	PCP: $0 Copay Specialist: $30 Copay
Preventive/ Screening	Covered in Full (Office visit Copay may apply)
Emergency Room	$90 Copay
Urgently Needed Services	$50 Copay
Lab & Diagnostic Tests*	Office/Lab: $0 Copay Outpatient: $30 Copay
X-Rays*/ Advanced Imaging*	X-ray: $30 Copay Advanced Imaging: $250 Copay
Hearing Services	Medicare Covered: $30 Copay Routine: $30 Copay (1 Per Year) TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year)
Dental Services	Medicare Covered: $30 Copay Office Visit: $0 Copay (1 Per Six Months) X-Rays: $0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum $500 allowance (Per Year)
Vision Services	Medicare Covered: $30 Copay Routine: $0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services*	Inpatient: $425/day Copay (days 1-3), $0/day Copay (days 4-90) Outpatient: $40 Copay
Skilled Nursing Facility*	$0/day Copay (days 1-20); $178/day Copay (days 21-100)
Physical Therapy*	$35 Copay
Ambulance (per one-way trip)**	Emergent/Non-Emergent: $275 Copay
Transportation*	$0 Copay
Part B Drugs*	20% Coinsurance
OTC	$25 Allowance Once Per Quarter
Routine Podiatry	$30 Copay (4 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance
Fitness Benefit	Covered in Full
Formulary	Performance

*Indicates a service that requires prior authorization.
**Indicates a service that requires prior authorization for non-emergent trips.

[1]ASC=Ambulatory Surgery Center

Community Blue Medicare HMO Prestige
$246
$0
$0
$6,700
$225 Copay Per Admit
ASC[1]: $75 Copay Facility: $200 Copay
PCP: $0 Copay Specialist: $25 Copay
Covered in Full (Office visit Copay may apply)
$90 Copay
$50 Copay
Office/Lab: $0 Copay Outpatient: $10 Copay
X-ray: $20 Copay Advanced Imaging: $100 Copay
Medicare Covered: $25 Copay Routine: $25 Copay (1 Per Year) TruHearing Advanced: $499 Copay; TruHearing Premium: $799 Copay (2 Aids Every Year)
Medicare Covered: $25 Copay Office Visit: $15 Copay (1 Per Six Months) X-Rays: $15 Copay (1 Per Six Months) Comprehensive: 50% Coinsurance with a maximum $250 allowance
Medicare Covered: $25 Copay Routine: $0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames or a $150 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Inpatient: $225 Copay Per Admit Outpatient: $40 Copay
$0/day Copay (days 1-20); $178/day Copay (days 21-100)
$30 Copay
Emergent/Non-Emergent: $125 Copay
$0 Copay
20% Coinsurance
Not Covered
$25 Copay (10 Visits Per Year)
20% Coinsurance
Covered in Full
Venture

*Indicates a service that requires prior authorization.
**Indicates a service that requires prior authorization for non-emergent trips.

[1]ASC=Ambulatory Surgery Center

Community Blue Medicare HMO Signature

DRUG

You pay the following until your total yearly drug costs reach $4,020.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$21 Copay	$21 Copay
Tier 2 (Generic)	$45 Copay	$45 Copay
Tier 3 (Preferred Brand)	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$15 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$12 Copay	$12 Copay
Tier 3 (Preferred Brand)	$120 Copay	$120 Copay
Tier 4 (Non-Preferred Drug)	$275 Copay	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Community Blue Medicare HMO Prestige

DRUG

You pay the following until your total yearly drug costs reach $4,020.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$15 Copay	$15 Copay
Tier 2 (Generic)	$57 Copay	$57 Copay
Tier 3 (Preferred Brand)	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$27 Copay	$27 Copay
Tier 3 (Preferred Brand)	$115 Copay	$115 Copay
Tier 4 (Non-Preferred Drug)	$275 Copay	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table On Next Page

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Community Blue Medicare HMO Prestige Coverage Gap Table

Coverage Gap	Standard Network	Tier	
		Tier 1 (Preferred Generic)	$5 Copay
		Tier 2 (Generic)	$19 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	$0
		Tier 2 (Generic)	$13
		Tiers 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage Products.

Highmark Choice Company is an HMO plan with a Medicare contract. Enrollment in Highmark Choice Company depends on contract renewal. Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association.

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

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SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program. TruHearing is a registered trademark of TruHearing, Inc.

HIGHMARK

WESTERN PENNSYLVANIA

Community Blue Medicare HMO

Summary of Benefits

January 1, 2020 to December 31, 2020

The service area for these plans includes the following counties:

Bedford, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Somerset, Venango and Warren

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You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com.** Or, call us and we'll send you a copy of the formulary.

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Travel Benefits (PPO)

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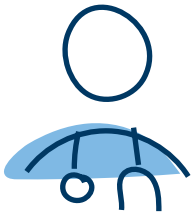

Telemedicine

Face-to-face with a doctor, 24/7.

Highmark House Call

Once-a-year in-home health review.

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Western Pennsylvania

	Community Blue Medicare HMO Signature
Premium	$0
Part B Premium Reduction	$3
Deductible	$0
Max Out-Of-Pocket	$6,700
Inpatient Hospital Stay*	$295 Copay Per Admit
Outpatient Hospital Coverage*	ASC[1]: $225 Copay Facility: $275 Copay
Doctor Office Visit	PCP: $0 Copay Specialist: $30 Copay
Preventive/ Screening	Covered in Full (Office visit Copay may apply)
Emergency Room	$90 Copay
Urgently Needed Services	$50 Copay
Lab & Diagnostic Tests*	Office/Lab: $0 Copay Outpatient: $30 Copay
X-Rays*/ Advanced Imaging*	X-ray: $30 Copay Advanced Imaging: $250 Copay
Hearing Services	Medicare Covered: $30 Copay Routine: $30 Copay (1 Per Year) TruHearing Advanced: $699 Copay; TruHearing Premium: $999 Copay (2 Aids Every Year)
Dental Services	Medicare Covered: $30 Copay Office Visit: $0 Copay (1 Per Six Months) X-Rays: $0 Copay (1 Per Year) Comprehensive: 50% Coinsurance with a maximum $500 allowance (Per Year)
Vision Services	Medicare Covered: $30 Copay Routine: $0 Copay (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames or a $100 benefit maximum for specialty contact lenses per year. $200 benefit maximum for post cataract eyewear (once per operated eye).
Mental Health Services*	Inpatient: $425/day Copay (days 1-3), $0/day Copay (days 4-90) Outpatient: $40 Copay
Skilled Nursing Facility*	$0/day Copay (days 1-20); $178/day Copay (days 21-100)
Physical Therapy*	$35 Copay
Ambulance (per one-way trip)**	Emergent/Non-Emergent: $275 Copay
Transportation*	$0 Copay
Part B Drugs*	20% Coinsurance
OTC	$25 Allowance Once Per Quarter
Routine Podiatry	$30 Copay (4 Visits Per Year)
Durable Medical Equipment*	20% Coinsurance
Fitness Benefit	Covered in Full
Formulary	Performance

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Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$21 Copay	$21 Copay
Tier 2 (Generic)	$45 Copay	$45 Copay
Tier 3 (Preferred Brand)	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$15 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$12 Copay	$12 Copay
Tier 3 (Preferred Brand)	$120 Copay	$120 Copay
Tier 4 (Non-Preferred Drug)	$275 Copay	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $6,350, you pay the greater of: 5% of the cost, or $3.60 Copay for generics and a $8.95 Copay for all other drugs.

Greater of: 5% or $3.60 Generic / Preferred Multi-Source or $8.95 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage Products.

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