HIGHMARK

Southwestern Pennsylvania

Community Blue Medicare HMO

Summary of Benefits

January 1, 2024 to December 31, 2024

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

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

This summary of benefits doesn't list every service, limitation, or special circumstance.
Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-888-234-5397** (TTY 711). We're available 8 a.m. to 8 p.m., 7 days a week.

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 **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

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

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	Community Blue Medicare HMO Prestige
Premium	$41.00
Part B Premium Reduction	$0.00
Deductible	$0
Max Out-Of-Pocket	$5,500
Inpatient Hospital Stay*	$200 copay per admit
Outpatient Hospital Coverage*	ASC[1]: $75 copay Facility: $150 copay
Doctor Office Visit	PCP: $0 copay Specialist: $0 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)
Emergency Room	$100 copay
Urgently Needed Services	$20 copay
Lab & Diagnostic Tests*	Office /Lab: $0 copay; Outpatient: $0 copay
X-Rays*/ Advanced Imaging*	X-ray: $20 copay Advanced Imaging: $95 copay
Hearing Services	Medicare Covered: $0 copay. Routine: $0 copay (1 Per Year). TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay (2 Aids Every Year)
Dental Services	Medicare Covered*: $0 copay. Office Visit: $0 copay (1 per six months). X-Rays: $0 copay (1 per six months). Comprehensive*: 0% coinsurance with a maximum $3,500 allowance (preventive and comprehensive combined) (Per Year).
Vision Services	Medicare Covered: $0 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 max for specialty contact lenses per year. $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services*	Inpatient: $225 copay per admit; Outpatient: $30 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $203 copay/day (days 21-100)
Physical Therapy*	$10 copay
Ambulance (per one-way trip)**	Emergent/Non-Emergent: $175 copay
Transportation*	$0 copay
Part B Drugs*†	20% coinsurance
OTC	$75 allowance once per quarter
Durable Medical Equipment*	20% coinsurance
Fitness Benefit	Covered in full
Formulary	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips. ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Community Blue Medicare HMO Prestige

DRUG

You pay the following until your total yearly drug costs reach $5,030.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible: $0

Initial Coverage

Preferred Retail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Select Insulin)	$20 Copay	$60 Copay
Tier 3 (Preferred Brand)	$40 Copay	$120 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Retail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Select Insulin)	$20 Copay	$60 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$0 Copay
Tier 3 (Preferred Select Insulin)	Not Applicable	$60 Copay
Tier 3 (Preferred Brand)	Not Applicable	$92.50 Copay
Tier 4 (Insulin)	Not Applicable	$105 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	Not Applicable	$15 Copay
Tier 2 (Generic)	Not Applicable	$57 Copay
Tier 3 (Preferred Select Insulin)	Not Applicable	$60 Copay
Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
Tier 4 (Insulin)	Not Applicable	$105 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap: The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. 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 $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table Below

Catastrophic Coverage: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	$0 Copay
		Tier 2 (Generic)	$0 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	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

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, Freedom Blue PPO, and Complete Blue PPO Medicare Advantage Products.

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

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: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company, which are independent licensees of the Blue Cross Blue Shield Association. The Blue Cross© Blue Shield© and Cross and Shield Symbols are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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.

This information is not a complete description of benefits. Call 1-866-687-3182 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing is a registered trademark of TruHearing, Inc.