HIGHMARK

Northwestern Pennsylvania

Complete Blue PPO

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:

Crawford, Erie, Forest, Lawrence, McKean, Mercer, Potter, Venango, Warren

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 **1-833-227-9375** (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.

Complete Blue PPO has a network of pharmacies. The out-of-network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

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	Complete Blue PPO Signature	Complete Blue PPO Distinct
Premium	$0.00	$27.00
Part B Premium Reduction	$10.00	$0.00
Deductible	$0	$0
Max Out-Of-Pocket	$6,500 IN; $8,950 combined IN and OON	$5,500 IN; $9,550 combined IN and OON
Inpatient Hospital Stay	$250 copay per admit IN*; $475 copay per admit OON	$225 copay per admit IN*; $225 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $175 copay IN*; $300 copay OON Facility: $225 copay IN*; $350 copay OON	ASC[1]: $175 copay IN*; $175 copay OON Facility: $200 copay IN*; $200 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $20 copay IN; $20 copay OON	PCP: $0 copay IN; $0 copay OON Specialist: $10 copay IN; $10 copay OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON	Covered in Full (Office visit copays may apply) IN/OON
Emergency Room	$100 copay IN/OON	$100 copay IN/OON
Urgently Needed Services	$50 copay IN/OON	$30 copay IN/OON
Lab & Diagnostic Tests	Office /Lab: $0 copay IN*; $25 copay OON; Outpatient: $0 copay IN*; $25 copay OON	Office /Lab: $0 copay IN*; $0 copay OON; Outpatient: $0 copay IN*; $0 copay OON
X-Rays/ Advanced Imaging	X-ray: $20 copay IN*; $30 copay OON Advanced Imaging: $195 copay IN*; $300 copay OON	X-ray: $20 copay IN*; $20 copay OON Advanced Imaging: $175 copay IN*; $175 copay OON
Hearing Services	Medicare Covered: $20 copay IN; $20 copay OON. Routine: $20 copay IN; $20 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year); $500 allowance IN/OON (per year)	Medicare Covered: $10 copay IN; $10 copay OON. Routine: $10 copay IN; $10 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year); $500 allowance IN/OON (per year)
Dental Services	Medicare Covered*: $20 copay IN; $20 copay OON. Office Visit: $0 copay IN; 30% coinsurance OON (1 per six months). X-Rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive*: 20% coinsurance IN; 50% coinsurance OON; with a maximum $2,500 allowance (preventive and comprehensive combined) IN/OON (Per Year)	Medicare Covered*: $10 copay IN; $10 copay OON. Office Visit: $0 copay IN; 30% coinsurance OON (1 per six months). X-Rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive*: 10% coinsurance IN; 50% coinsurance OON; with a maximum $3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year)
Vision Services	Medicare Covered: $20 copay IN; $20 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max 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).	Medicare Covered: $10 copay IN; $10 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max 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: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay per admit IN*; Days 1 - 3: $500 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON; Outpatient: $40 copay IN*; $60 copay OON	Inpatient: Days 1 - 3: $425 copay per day per admit & Days 4 - 90: $0 copay per admit IN*; Days 1 - 3: $475 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON; Outpatient: $40 copay IN*; $40 copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $203 copay/day (days 21-100) IN*; 30% coinsurance OON	$0 copay/day (days 1-20), $203 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$20 copay IN*; $30 copay OON	$5 copay IN*; $5 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	$0 copay IN*; 30% coinsurance OON	$0 copay IN*; 30% coinsurance OON
Part B Drugs[†]	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
OTC	$130 allowance once per quarter IN/OON	$200 allowance once per quarter IN/OON
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Fitness Benefit	SilverSneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON	SilverSneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Performance	Performance

	Complete Blue PPO Premier
Premium	$46.00
Part B Premium Reduction	$0.00
Deductible	$0
Max Out-Of-Pocket	$4,900 IN; $8,950 combined IN and OON
Inpatient Hospital Stay	$225 copay per admit IN*; $225 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $175 copay IN*; $175 copay OON Facility: $200 copay IN*; $200 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $0 copay IN; $0 copay OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON
Emergency Room	$100 copay IN/OON
Urgently Needed Services	$15 copay IN/OON
Lab & Diagnostic Tests	Office /Lab: $0 copay IN*; $0 copay OON; Outpatient: $0 copay IN*; $0 copay OON
X-Rays/ Advanced Imaging	X-ray: $10 copay IN*; $10 copay OON Advanced Imaging: $150 copay IN*; $150 copay OON
Hearing Services	Medicare Covered: $0 copay IN; $0 copay OON. Routine: $0 copay IN; $0 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year); $500 allowance IN/OON (per year)
Dental Services	Medicare Covered*: $0 copay IN; $0 copay OON. Office Visit: $0 copay IN; 30% coinsurance OON (1 per six months). X-Rays: $0 copay IN; 30% coinsurance OON (1 per year). Comprehensive*: 0% coinsurance IN; 50% coinsurance OON; with a maximum $3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year)
Vision Services	Medicare Covered: $0 copay IN; $0 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max 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: $300 copay per admit IN*; $300 copay per admit OON; Outpatient: $30 copay IN*; $30 copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $203 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$0 copay IN*; $0 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation	$0 copay IN*; 30% coinsurance OON
Part B Drugs†	20% coinsurance IN*; 30% coinsurance OON
OTC	$120 allowance once per quarter IN/OON
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON
Fitness Benefit	SilverSneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
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.

Complete Blue PPO Signature

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 Insulin)	$35 Copay	$105 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
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$15 Copay	$45 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$120 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	$21 Copay
		Tier 2 (Generic)	Not Applicable	$45 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 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.			
	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 $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.

Complete Blue PPO Distinct

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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 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
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$20 Copay	$60 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$280 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	$21 Copay
		Tier 2 (Generic)	Not Applicable	$60 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 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.			
	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 $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.

Complete Blue PPO Premier

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 Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 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
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
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		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 Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$120 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$280 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	$21 Copay
		Tier 2 (Generic)	Not Applicable	$60 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 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.			
	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 $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.

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.

Out-of-network/non-contracted providers are under no obligation to treat Complete Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-833-544-1060 (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.

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