



## Central and Northeastern Pennsylvania

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# Community Blue Medicare HMO Summary of Benefits

January 1, 2026 to December 31, 2026

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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:

**Franklin, Fulton, Monroe, Schuylkill, Susquehanna, Tioga**

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 7 days a week, 8 a.m. to 8 p.m.

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.

|                                     | Community Blue Medicare HMO Signature (HMO)                                                                                                                                                                                                                                                                                                    | Community Blue Medicare HMO Distinct (HMO)                                                                                                                                                                                                                                                                                                      |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Premium                             | \$0                                                                                                                                                                                                                                                                                                                                            | \$55                                                                                                                                                                                                                                                                                                                                            |
| Part B Premium Reduction            | \$17                                                                                                                                                                                                                                                                                                                                           | \$0                                                                                                                                                                                                                                                                                                                                             |
| Deductible                          | \$0                                                                                                                                                                                                                                                                                                                                            | \$0                                                                                                                                                                                                                                                                                                                                             |
| Max Out-Of-Pocket                   | \$6,500                                                                                                                                                                                                                                                                                                                                        | \$6,250                                                                                                                                                                                                                                                                                                                                         |
| Inpatient Hospital Stay*            | \$250 copay per admit                                                                                                                                                                                                                                                                                                                          | \$400 copay per admit                                                                                                                                                                                                                                                                                                                           |
| Outpatient Hospital Coverage*       | ASC <sup>1</sup> : \$125 copay<br>Facility: \$175 copay                                                                                                                                                                                                                                                                                        | ASC <sup>1</sup> : \$250 copay<br>Facility: \$300 copay                                                                                                                                                                                                                                                                                         |
| Doctor Office Visit                 | PCP: \$0 copay<br>Specialist: \$0 copay                                                                                                                                                                                                                                                                                                        | PCP: \$0 copay<br>Specialist: \$35 copay                                                                                                                                                                                                                                                                                                        |
| Preventive/Screening                | Covered in Full (Office visit copays may apply)                                                                                                                                                                                                                                                                                                | Covered in Full (Office visit copays may apply)                                                                                                                                                                                                                                                                                                 |
| Emergency Room                      | \$130 copay                                                                                                                                                                                                                                                                                                                                    | \$130 copay                                                                                                                                                                                                                                                                                                                                     |
| Urgently Needed Services            | \$40 copay                                                                                                                                                                                                                                                                                                                                     | \$40 copay                                                                                                                                                                                                                                                                                                                                      |
| Lab* & Diagnostic Tests*            | Freestanding Lab: \$0 copay<br>Office/Outpatient: \$10 copay                                                                                                                                                                                                                                                                                   | Freestanding Lab: \$0 copay<br>Office/Outpatient: \$10 copay                                                                                                                                                                                                                                                                                    |
| X-Rays*/ Advanced Imaging*          | X-ray: \$10 copay<br>Advanced Imaging: \$200 copay                                                                                                                                                                                                                                                                                             | X-ray: \$10 copay<br>Advanced Imaging: \$250 copay                                                                                                                                                                                                                                                                                              |
| Hearing Services                    | Medicare Covered: \$0 copay.<br>Routine: \$0 copay (1 Per Year).<br>TruHearing Advanced: \$699 copay (2 Aids Every Year);<br>TruHearing Premium: \$999 copay (2 Aids Every Year)                                                                                                                                                               | Medicare Covered: \$35 copay.<br>Routine: \$0 copay (1 Per Year).<br>TruHearing Advanced: \$699 copay (2 Aids Every Year);<br>TruHearing Premium: \$999 copay (2 Aids Every Year)                                                                                                                                                               |
| Dental Services                     | Medicare Covered: \$0 copay.<br>Routine Office Visit: \$0 copay (2 per year).<br>Routine X-rays: \$0 copay (1 per year).<br>Comprehensive 0% coinsurance with a maximum \$3,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.                                                                   | Medicare Covered: \$35 copay.<br>Routine Office Visit: \$0 copay (2 per year).<br>Routine X-rays: \$0 copay (1 per year).<br>Comprehensive 0% coinsurance with a maximum \$3,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.                                                                   |
| Vision Services                     | Medicare Covered: \$0 copay.<br>Routine Office: \$0 copay (1 Every Year). Standard Eyeglass lenses and frames or contact lenses are covered in full. A \$200 benefit max applies to non-standard frames or a \$200 benefit max for specialty contact lenses per year or a \$200 benefit max for post cataract eyewear (once per operated eye). | Medicare Covered: \$35 copay.<br>Routine Office: \$0 copay (1 Every Year). Standard Eyeglass lenses and frames or contact lenses are covered in full. A \$200 benefit max applies to non-standard frames or a \$200 benefit max for specialty contact lenses per year or a \$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*; Outpatient: \$30 copay                                                                                                                                                                                                                               | Inpatient: Days 1 - 3: \$425 copay per day per admit & Days 4 - 90: \$0 copay per admit*; Outpatient: \$30 copay                                                                                                                                                                                                                                |
| Skilled Nursing Facility*           | \$0 copay/day (days 1 - 20), \$218 copay/day (days 21 - 100)                                                                                                                                                                                                                                                                                   | \$0 copay/day (days 1 - 20), \$218 copay/day (days 21 - 100)                                                                                                                                                                                                                                                                                    |
| Physical Therapy                    | \$20 copay*                                                                                                                                                                                                                                                                                                                                    | \$25 copay*                                                                                                                                                                                                                                                                                                                                     |
| Ambulance (per one-way trip)*(**)   | Emergent/Non-Emergent: \$215 copay                                                                                                                                                                                                                                                                                                             | Emergent/Non-Emergent: \$345 copay                                                                                                                                                                                                                                                                                                              |
| Transportation*                     | \$0 copay                                                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                       |
| Medicare Part B Drugs* <sup>†</sup> | 20% coinsurance                                                                                                                                                                                                                                                                                                                                | 20% coinsurance                                                                                                                                                                                                                                                                                                                                 |
| OTC                                 | \$40 allowance once per quarter                                                                                                                                                                                                                                                                                                                | \$40 allowance once per quarter                                                                                                                                                                                                                                                                                                                 |
| Durable Medical Equipment*          | 0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.                                                                                                                                                                        | 0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items.                                                                                                                                                                         |
| Formulary                           | Performance                                                                                                                                                                                                                                                                                                                                    | Performance                                                                                                                                                                                                                                                                                                                                     |

\*Indicates a service that requires prior authorization.

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

ASC<sup>1</sup>=Ambulatory Surgery Center

<sup>†</sup>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 Signature (HMO)**

After you pay your yearly deductible (excludes insulins), you pay the following until your total yearly drug costs reach \$2,100. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| Deductible            |                               | Tier 1-Tier 2: \$0, Tier 3-5: \$615                                                                                                                                                                                     |                 |                              |
|-----------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------|
| 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)                                                                                                                                                                                                | 20% of the cost | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | \$35 Copay      | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | 25% of the cost | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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)                                                                                                                                                                                                | 20% of the cost | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | \$35 Copay      | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | 25% of the cost | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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  | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | Not Applicable  | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | Not Applicable  | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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  | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | Not Applicable  | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | Not Applicable  | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% of the cost | Not Applicable               |
| Catastrophic Coverage |                               | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$2,100, 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 Distinct (HMO)**

After you pay your yearly deductible (excludes insulins), you pay the following until your total yearly drug costs reach \$2,100. Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| Deductible            |                               | Tier 1-Tier 2: \$0, Tier 3-5: \$615                                                                                                                                                                                     |                 |                              |
|-----------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------|
| 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)                                                                                                                                                                                                | 20% of the cost | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | \$35 Copay      | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | 25% of the cost | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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)                                                                                                                                                                                                | 20% of the cost | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | \$35 Copay      | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | 25% of the cost | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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  | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | Not Applicable  | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | Not Applicable  | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% 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  | 20% of the cost              |
|                       |                               | Tier 4 (Insulin)                                                                                                                                                                                                        | Not Applicable  | \$105 Copay                  |
|                       |                               | Tier 4 (Non-Preferred Drug)                                                                                                                                                                                             | Not Applicable  | 25% of the cost              |
|                       |                               | Tier 5 (Specialty Tier)                                                                                                                                                                                                 | 25% of the cost | Not Applicable               |
| Catastrophic Coverage |                               | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$2,100, 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 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 Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. The Blue Shield® and Shield Symbol 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 1-866-746-7971 (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. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.