

Western New York

Senior Blue & BlueSaver (HMO)

Summary of Benefits

January 1, 2025 to December 31, 2025

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:

Allegany, Cattaraugus, Chautaugua, Erie, Genesee, Niagara, Orleans, Wyoming

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 **1-800-329-2792** (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.

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.

Senior Blue & BlueSaver (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.

	Senior Blue Basic (HMO)	BlueSaver (HMO)
Premium	\$0.00	\$0.00
Part B Premium Reduction	\$71.00	\$4.00
Deductible	\$0	\$0
Max Out-Of-Pocket	\$8,300	\$6,900
Inpatient Hospital Stay*	Days 1 -6: \$375 copay per day per admit & Days 7- 90: \$0 copay per admit \$2,250 OOP Max per year for IN	Days 1 - 6: \$350 copay per day per admit & Days 7 - 90: \$0 copay per admit \$2,100 OOP Max per year for IN
Outpatient Hospital Coverage*	ASC¹: \$425 copay Facility: \$475 copay	ASC¹: \$275 copay Facility: \$375 copay
Doctor Office Visit	PCP: \$10 copay Specialist: \$50 copay	PCP: \$0 copay Specialist: \$30 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)	Covered in Full (Office visit copays may apply)
Emergency Room	\$110 copay	\$110 copay
Urgently Needed Services	\$45 copay	\$45 copay
Lab* & Diagnostic Tests*	Office Lab: \$10 copay; Outpatient Lab: \$10 copay Diagnostic Tests: \$60 copay	Office Lab: \$0 copay; Outpatient Lab: \$0 copay Diagnostic Tests: \$50 copay
X-Rays*/ Advanced Imaging*	X-ray: \$50 copay Advanced Imaging: \$225 copay	X-ray: \$45 copay Advanced Imaging: \$175 copay
Hearing Services	Medicare Covered: \$50 copay IN Routine: Not Covered; TruHearing Advanced: Not Covered; TruHearing Premium; Not Covered	Medicare Covered: \$30 copay. Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year)
Dental Services	Medicare Covered: \$50 copay. Routine Office Visit: \$20 copay per service (1 per six months). Routine X-rays: \$20 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$1,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.	Medicare Covered: \$30 copay. Routine Office Visit: \$0 copay per service (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (preventive and comprehensive combined) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: \$50 copay. \$0 diabetic retinal eye exam. Routine: \$25 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery.	Medicare Covered: \$30 copay. \$0 diabetic retinal eye exam. Routine: \$25 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 6: \$335 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$2,010 OOP Max per year; Outpatient: \$40 copay	Inpatient: Days 1 - 4: \$395 copay per day per admit & Days 5 - 90: \$0 copay per admit*; \$1,580 OOP Max per year; Outpatient: \$40 copay
Skilled Nursing Facility*	\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)	\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)
Physical Therapy*	\$40 copay	\$30 copay
Ambulance (per one- way trip)*	\$275 copay	\$270 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs* [†]	20% coinsurance	20% coinsurance
OTC	Not Covered	\$140 allowance once per quarter
Flex Card	Not Covered	Not Covered
Durable Medical Equipment*	20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts	20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts
Formulary	Fundamental	Fundamental

	Senior Blue 651 (HMO)	Senior Blue Select (HMO)
Premium	\$101.00	\$40.00
Part B Premium Reduction	\$0.00	\$0.00
Deductible	\$0	\$0
Max Out-Of-Pocket	\$6,700	\$6,700
Inpatient Hospital Stay*	Days 1 - 7: \$225 copay per day per admit & Days 8 - 90: \$0 copay per admit \$1,575 OOP Max per year	Days 1 - 5: \$335 copay per day per admit & Days 6 - 90: \$0 copay per admit \$1,675 OOP Max per year
Outpatient Hospital Coverage*	ASC¹: \$225 copay Facility: \$325 copay	ASC¹: \$300 copay Facility: \$400 copay
Doctor Office Visit	PCP: \$0 copay Specialist: \$25 copay	PCP: \$0 copay Specialist: \$30 copay
Preventive/Screening	Covered in Full (Office visit copays may apply)	Covered in Full (Office visit copays may apply)
Emergency Room	\$125 copay	\$125 copay
Urgently Needed Services	\$55 copay	\$55 copay
Lab* & Diagnostic Tests*	Office Lab: \$5 copay; Outpatient Lab: \$5 copay Diagnostic Tests: \$40 copay	Office Lab: \$0 copay; Outpatient Lab: \$0 copay Diagnostic Tests: \$50 copay
X-Rays*/ Advanced Imaging*	X-ray: \$40 copay Advanced Imaging: \$150 copay	X-ray: \$45 copay Advanced Imaging: \$175 copay
Hearing Services	Medicare Covered: \$25 copay. Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$499 copay; TruHearing Premium: \$799 copay (2 Aids Every Year)	Medicare Covered: \$30 copay. Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$499 copay; TruHearing Premium: \$799 copay (2 Aids Every Year)
Dental Services	Medicare Covered: \$25 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits.	Medicare Covered: \$30 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: \$25 copay. \$0 diabetic retinal eye exam. Routine: \$25 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$200 annual eyewear allowance.	Medicare Covered: \$30 copay. \$0 diabetic retinal eye exam. Routine: \$25 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$200 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 6: \$215 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,290 OOP Max per year; Outpatient: \$40 copay	Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay
Skilled Nursing Facility*	\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)	\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)
Physical Therapy*	\$15 copay	\$25 copay
Ambulance (per one- way trip)*	\$200 copay	\$300 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs* [†]	20% coinsurance	20% coinsurance
OTC	\$60 allowance once per quarter	\$70 allowance once per quarter
Flex Card	Not Covered	Not Covered
Durable Medical Equipment*	20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts	20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts
Formulary	Fundamental	Fundamental

Premium Si.00 Si		Senior Blue 601 (HMO)
Part Beduction \$1.00 Deductible \$0 Max Out-Of-Pooket \$6,700 Inpatient Hospital \$6,700 Stay* \$2,030 OOP Max per year Outpatient Hospital Coverage* Pack (1), \$325 copay Coverage* PCP- \$5 copay Specialist: \$45 copay Preventive/Screening Covered in Full (Office visit copays may apply) Emergency Room \$125 copay Urgently Needed Services \$55 copay Scrivices Office Lab: \$0 copay, Outpatient Lab: \$0 copay Lab* & Diagnostic Persis: \$45 copay Hearing Services Medicare Covered: \$45 copay Hearing Services Medicare Covered: \$45 copay Respective Partition (For full benefits) Medicare Covered: \$45 copay Proprieture (For full benefits) S0 copay (1 per year) Proprieture (For full benefits) S0 copay (1 per year) Proprieture (For full benefits) S0 copay (1 per year) Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the For full benefits) Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copa	Premium	
Max Out-Of-Pocket \$6,700 Inpatient Hospital \$2,300 OOP Max per year Outpatient Hospital ASC': \$225 copay Poctor Office Visit PCP. \$5 copay Preventive/Screening Covered in Full (Office visit copays may apply) Emergency Room \$125 copay Urgently Needed \$55 copay Services \$55 copay Lab* & Diagnostic Office Lab: \$0 copay; Outpatient Lab: \$0 copay Testis Office Lab: \$0 copay; Outpatient Lab: \$0 copay Harring Services Medicare Covered: \$45 copay Realing Services Medicare Covered: \$45 copay Medicare Covered: \$45 copay Medicare Covered: \$45 copay Potable Services Medicare Covered: \$45 copay Medicare Covered: \$45 copay, TartHearing Premium: \$899 copay; TartHearing Premium: \$899 copay; (2 Aids Every Year) Turblearing Advanced: \$599 copay; TartHearing Premium: \$899 copay; (2 Aids Every Year) Westiant Health Medicare Covered: \$45 copay. Medicare Covered: \$45 copay. Medicare Covered: \$45 copay. Routine Strives: \$0 copay (1 per year). Comprehensive: \$60% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). Vision Ser	Part B Premium	·
Inpatient Hospital Stay* Days 1 - 7: \$290 copay per admit & Days 8 - 90: \$0 copay per admit \$2,030 OOP Max per year Outpatient Hospital Coverage* \$2,030 OOP Max per year Doctor Office Visit \$25: \$225 copay Facility: \$325 copay Preventive/Screening Covered in Full (Office visit copays may apply) Emergency Room \$125 copay Urgently Needed Services \$55 copay Lab* & Diagnostic Tests: \$45 copay \$40 copay X-Rays* / Advanced Imaging: \$150 copay X-ray: \$45 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay. Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine: \$45 copay.	Deductible	\$0
Stay* \$2,030 OOP Max per year Outpatient Hospital Coverage* ASC': \$225 copay Facility: \$325 copay Coverage* Facility: \$325 copay Preventive/Screening Covered in Full (Office visit copays may apply) Emergency Room \$125 copay Urgently Needed Services \$55 copay Lab* & Diagnostic Tests* East So Diagnostic Tests: Office Lab: \$0 copay, Outpatient Lab: \$0 copay Tests* Direct Lab: \$0 copay, Outpatient Lab: \$0 copay Hearing Services Variay: \$45 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay (I Per Year), Trullearing Advanced inaging: \$150 copay Preventive: \$45 copay (I Per Year), Trullearing Premium: \$899 copay; Trullearing Premium: \$899 copay; (I per year). Vision Services Medicare Covered: \$45 copay. Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (I per six months). Vision Services Medicare Covered: \$45 copay. Vision Services Medicare Covered: \$45 copay. S0 diabetic retinal eye exam. Routine: \$0 copay (I per year). So copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Impatie	Max Out-Of-Pocket	\$6,700
Coverage* Facility: \$325 copay Doctor Office Visit PCP: Scopay Specialis: \$45 copay Urgently Needed Services \$55 copay Lab* & Diagnostic Tests: Office Lab: \$0 copay, Outpatient Lab: \$0 copay Tests* Diffice Lab: \$0 copay, Outpatient Lab: \$0 copay Tests* Diffice Lab: \$0 copay, Outpatient Lab: \$0 copay Labraging* X-ray: \$45 copay X-Rays*/ Advanced Imaging: \$150 copay Advanced Imaging: \$150 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$599 copay; TruHearing Advanced: \$599 copay; Routine: \$45 copay (1 Per year). Comprehensive: \$0% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the Experimental Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). Comprehensive: \$0% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). So copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay per admirt*, \$1,560 OOP Max per year; Outpatient: \$40 copay Skilled Nursing Facility* \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) Facility* \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) Facilit	•	, , , , , , , , , , , , , , , , , , , ,
Preventive/Screening Covered in Full (Office visit copays may apply)	Coverage*	Facility: \$325 copay
Emergency Room \$125 copay Urgently Needed Services \$55 copay Eab* & Diagnostic Tests* Office Lab. \$0 copay; Outpatient Lab: \$0 copay Tests* Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging: \$150 copay Hearing Services Medicare Covered: \$45 copay TrulHearing Advanced: \$599 copay; TrulHearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay Routine Office Visit: \$0 copay (1 per year). Routine Variay: \$0 copay (1 per year). Routine Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). Soc opay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Inpatient: Days 1 - 6: \$260 copay per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay Skilled Nursing Facility* \$15 copay Facility* \$20 copay/day (days 1-20), \$214 copay/day (days 21-100) Facility* \$15 copay Transportation Not Covered Medicare Part B Drugs** 20% coinsurance Out Covered	Doctor Office Visit	
Urgently Needed Services \$55 copay Lab* & Diagnostic Tests* Office Lab: \$0 copay; Outpatient Lab: \$0 copay Lab* & Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* X-ray: \$45 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay. (Per Year). TruHearing Advanced: \$599 copay; TruHearing Permium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits. Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; \$0 copay (1 per year). \$0 copay	Preventive/Screening	Covered in Full (Office visit copays may apply)
Services Lab* & Diagnostic Tests: \$45 copay Tests* Office Lab: \$0 copay, Outpatient Lab: \$0 copay Tests* Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging: \$150 copay X-ray: \$45 copay Hearing Services Medicare Covered: \$45 copay, TruHearing Advanced: \$599 copay; TruHearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits. Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). See the EOC for full benefits. Mental Health Eoc		• •
Tests* Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* X-ray: \$45 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay (1 Per Year). Trul learing Advanced: \$599 copay; Trul learing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (1 per six months). Routine Office Visit: \$0 copay (1 per year). Comprehensive: \$0% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits. Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay Skilled Nursing Facility* \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) Physical Therapy* \$15 copay Ambulance (per oneway trip)* \$200 copay Transportation Not Covered Medicare Part B Drugs** 20% coinsurance OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* 20% coinsurance So copay for compression stockings, diabetic shoes/inserts <td>0 ,</td> <td>\$55 copay</td>	0 ,	\$55 copay
Imaging* Advanced Imaging: \$150 copay Hearing Services Medicare Covered: \$45 copay. Routine: \$45 copay (1 Per Year). TruHearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: \$0% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). \$80 copay (1 per year). Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). \$90 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; \$15 copay Skilled Nursing Facility* \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) Physical Therapy* \$15 copay Ambulance (per oneway trip)* \$200 copay way trip)* \$200 copay Transportation Not Covered Medicare Part B Drugs** 20% coinsurance Drugs** Not Covered Durable Medical Equipment* 20% coinsurance Equipment* \$0 copay for compression stockings, diabetic shoes/inserts		
Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$599 copay; TruHearing Pendium: \$899 copay (2 Aids Every Year) Medicare Covered: \$45 copay. Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay Skilled Nursing Facility* Physical Therapy* Ambulance (per one- way trip)* Transportation Not Covered Medicare Part B Drugs* OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* Routine: \$45 copay (1 per year). Sopay (1 per year). Services Onapy (1 per year). Services Onapy (1 per year). Sopay		
Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the EOC for full benefits. Vision Services Medicare Covered: \$45 copay. \$0 diabetic retinal eye exam. Routine: \$0 copay (1 per year). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health	Hearing Services	Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$599 copay;
So copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Inpatient: Days 1 - 6: \$260 copay per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay Skilled Nursing Facility* So copay/day (days 1-20), \$214 copay/day (days 21-100) Physical Therapy* \$15 copay Ambulance (per oneway trip)* \$200 copay Medicare Part B Drugs*† OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* 20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts	Dental Services	Routine Office Visit: \$0 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: 50% coinsurance with a maximum \$2,000 allowance (comprehensive services only) (per year). See the
Mental Health ServicesInpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copaySkilled Nursing Facility*\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)Physical Therapy*\$15 copayAmbulance (per oneway trip)*\$200 copayTransportationNot CoveredMedicare Part B Drugs*†20% coinsuranceOTC\$25 allowance once per quarterFlex CardNot CoveredDurable Medical Equipment*20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts	Vision Services	
Facility* Physical Therapy* \$15 copay Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs*† OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* \$0 copay for compression stockings, diabetic shoes/inserts		Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year;
Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs*† OTC \$25 allowance once per quarter Flex Card Durable Medical Equipment* \$20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts		\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)
Transportation Not Covered Medicare Part B Drugs* [†] OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* \$0 copay for compression stockings, diabetic shoes/inserts	Physical Therapy*	\$15 copay
Medicare Part B Drugs*† 20% coinsurance OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical Equipment* 20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts		\$200 copay
Drugs* [†] OTC \$25 allowance once per quarter Flex Card Not Covered Durable Medical 20% coinsurance Equipment* \$0 copay for compression stockings, diabetic shoes/inserts	Transportation	Not Covered
Flex Card Not Covered Durable Medical Equipment* Not Covered 20% coinsurance \$0 copay for compression stockings, diabetic shoes/inserts		20% coinsurance
Durable Medical 20% coinsurance Equipment* \$0 copay for compression stockings, diabetic shoes/inserts	OTC	\$25 allowance once per quarter
Equipment* \$0 copay for compression stockings, diabetic shoes/inserts	Flex Card	
Formulary Not Covered		
	Formulary	Not Covered

ASC¹=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.

^{*}Indicates a service that requires prior authorization.

Tier 5 (Specialty Tier)

Senior Blue Basic (HMO)

Catastrophic

Coverage

Not Applicable

33% of the cost

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order)

reaches \$2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Catastrophic

Coverage

Cost-	Tier 2 (Generic)	Not Applicable	\$0 Copay
Sharing	Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay
	Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
	Tier 4 (Insulin)	Not Applicable	\$105 Copay
	Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost
	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Standard	Tier 1 (Preferred Generic)	Not Applicable	\$12.50 Copay
Mail	Tier 2 (Generic)	Not Applicable	\$42.50 Copay
Cost-	Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay
Sharing	Tier 3 (Preferred Brand)	Not Applicable	25% of the cost
	Tier 4 (Insulin)	Not Applicable	\$105 Copay
	Tier 4 (Non-Preferred Drug)	Not Applicable	50% of the cost
	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
After your yea	arly out-of-pocket drug costs (includ	ing drugs purchased through your retail	pharmacy and through mail order)

reaches \$2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.

31 Day Supply

\$0 Copay

\$2 Copay

\$35 Copay

\$35 Copay

\$5 Copay

\$17 Copay

\$35 Copay

\$35 Copay

25% of the cost

50% of the cost

33% of the cost

Not Applicable

31 Day Supply

25% of the cost

50% of the cost

33% of the cost

31 Day Supply

100 Day (T1/2) 90 Day (T3/4)

100 Day (T1/2) 90 Day (T3/4)

100 Day (T1/2) 90 Day (T3/4)

\$0 Copay

\$6 Copay

\$105 Copay

\$105 Copay

\$15 Copay

\$51 Copay

\$105 Copay

\$105 Copay

\$0 Copay

25% of the cost

50% of the cost

Not Applicable

25% of the cost

50% of the cost

Not Applicable

Catastrophic Coverage

	Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4
Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
Retail Cost- Sharing	Tier 2 (Generic)	\$10 Copay	\$30 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)	\$94 Copay	\$282 Copay
	Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4
Standard	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay
Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay
Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay
Sharing	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
	Tion	lot Day Owner	400 Dev. /T4/2\ 00 Dev. /T2/4
	Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4
	Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
<i>l</i> lail			
/lail Cost-	Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
/lail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic)	Not Applicable Not Applicable	\$0 Copay \$25 Copay
/lail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin)	Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay
/lail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand)	Not Applicable Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay
/lail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay
/lail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable
Mail Cost- Sharing	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier)	Not Applicable 33% of the cost	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable
Mail Cost- Sharing Standard	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) Tier	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost 31 Day Supply	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable 100 Day (T1/2) 90 Day (T3/4)
Mail Cost- Sharing Standard Mail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost 31 Day Supply Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable 100 Day (T1/2) 90 Day (T3/4 \$17.50 Copay
Mail Cost- Sharing Standard Mail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost 31 Day Supply Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable 100 Day (T1/2) 90 Day (T3/4 \$17.50 Copay \$37.50 Copay
Mail Cost- Sharing Standard Mail Cost-	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable 100 Day (T1/2) 90 Day (T3/4 \$17.50 Copay \$37.50 Copay \$105 Copay
Preferred Mail Cost- Sharing Standard Mail Cost- Sharing	Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand) Tier 4 (Insulin) Tier 4 (Non-Preferred Drug) Tier 5 (Specialty Tier) Tier Tier 1 (Preferred Generic) Tier 2 (Generic) Tier 3 (Preferred Insulin) Tier 3 (Preferred Brand)	Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable 33% of the cost 31 Day Supply Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable Not Applicable	\$0 Copay \$25 Copay \$105 Copay \$105 Copay \$105 Copay \$235 Copay Not Applicable 100 Day (T1/2) 90 Day (T3/2 \$17.50 Copay \$37.50 Copay \$105 Copay \$117.50 Copay

Tier 5 (Specialty Tier)

Senior Blue Select (HMO)

Catastrophic

Coverage

Not Applicable

33% of the cost

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order)

reaches \$2,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.



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.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross°, Blue Shield°, Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex

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 1-866-682-7972 (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.