



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](https://www.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](https://www.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."

| | 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.

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.

Complete Blue PPO Signature

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. | | | |

DRUG

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

Complete Blue PPO Distinct

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. | | | |

DRUG

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

Complete Blue PPO Premier

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. | | | |

DRUG

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.