

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, Chautauqua, 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 S0.00 Part B Premium Reduction S1.00 Deductible S0 Max Out-Of-Pocket S6,700 Inpatient Hospital Stay* S2,030 OOP Max per year S2,000 OOP Max		Senior Blue 601 (HMO)
Part B Premium Reduction Deductible \$0 Max Out-Of-Pocket 16,700 Inpatient Hospital 5tay* \$2,000 OOP Max per year Outpatient Hospital Coverage* \$252 copay Facility: \$325 copa	Premium	
Max Out-Of-Pocket Inpatient Hospital Days 1 - 7: \$290 copay per day per admit & Days 8 - 90: \$0 copay per admit \$2,030 OOP Max per year \$2,000 O	Part B Premium	·
Inpatient Hospital Stay*	Deductible	\$0
Stay* S2,030 OOP Max per year Outpatient Hospital Coverage* Facility: \$325 copay Poctor Office Visit PCP: \$5 copay Specialist: \$45 copay Preventive/Screening Emergency Room S125 copay Preventive/Screening Emergency Room S125 copay Preventive/Screening Emergency Room S125 copay Specialist: \$45 copay Covered in Full (Office visit copays may apply) S55 copay S55 copay S56 copay Coffice Lab: \$0 copay; Outpatient Lab: \$0 copay Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging: \$150 copay Hearing Services Medicare Covered: \$45 copay Routine: \$45 copay (1 Per Year). Trul-Hearing Advanced: \$599 copay; Trul-Hearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay, 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 Skilled Nursing Facility* Physical Therapy* S15 copay S200 copay Medicare Part B Drugs** Not Covered 20% coinsurance	Max Out-Of-Pocket	\$6,700
Doctor Office Visit PCP: S5 copay PcP: S		, , , , , , , , , , , , , , , , , , , ,
Specialist: \$45 copay	Coverage*	Facility: \$325 copay
Emergency Room Urgently Needed Services Lab* & Diagnostic Tests* Office Lab: \$0 copay; Outpatient Lab: \$0 copay Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* Hearing Services Medicare Covered: \$45 copay Routine: \$45 copay (1 Per Year). 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). \$0 copay for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewear allowance. Mental Health Services Mental Health Services Skilled Nursing Facility* Physical Therapy* \$15 copay Ambulance (per one-way trip)* Transportation Not Covered Medicare Part B Drugs** Directions Outpatient: Abo copay Soutpatient: Abo copay Soutpatient: Abo copay Soutpatient: Soutpatient: Soutpatient (August 200) (A	Doctor Office Visit	
Urgently Needed Services Lab* & Diagnostic Tests* Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* Hearing Services Medicare Covered: \$45 copay, Routine: \$45 copay (1 Per Year), TruHearing Advanced: \$599 copay; TruHearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay, Routine: \$45 copay (1 per six months). Routine X-rays: \$0 copay (1 per year). Comprehensive: \$590 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 Mental Health Services Skilled Nursing Facility* Physical Therapy* \$0 copay/day (days 1-20), \$214 copay/day (days 21-100) Facility* Physical Therapy* Not Covered Medicare Part B Drugs** Drugs**	Preventive/Screening	Covered in Full (Office visit copays may apply)
Services Lab* & Diagnostic Tests: \$45 copay; Outpatient Lab: \$0 copay Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* Hearing Services Medicare Covered: \$45 copay, (1 Per Year). TruHearing Advanced: \$599 copay; TruHearing Premium: \$899 copay; (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay. Routine: \$45 copay. Routine X-rays: \$0 copay (1 per year). Comprehensive: \$60% 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 Skilled Nursing Facility* Physical Therapy* Ambulance (per oneway trip)* Stip Coopay (1 per year). Stip Copay (2 Aids Every Year) Stip Copay (3 Per year). Comprehensive: \$0 copay (1 per year). Stip Copay (2 Aids Every Year) Medicare Covered: \$45 copay. Stip Copay (1 per year). Stip Copay (2 Aids Every Year) Medicare Part B Drugs** Office Visit: \$45 copay Available Autoriance Description: \$45 copay Arbulance (per oneway trip)* Not Covered Medicare Part B Drugs**	Emergency Room	\$125 copay
Tests* Diagnostic Tests: \$45 copay X-Rays*/ Advanced Imaging* X-ray: \$45 copay Advanced Imaging* S150 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 V-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 Unpatient: \$40 copay Skilled Nursing Facility* Physical Therapy* Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs** Diagnostic Tests: \$45 copay Medicare Covered: \$45 copay An Every Year) Medicare Part B Drugs** Diagnostic Tests: \$45 copay Medicare Part B Drugs**		\$55 copay
Imaging*		
Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$599 copay; TruHearing Premium: \$899 copay (2 Aids Every Year) Dental Services Medicare Covered: \$45 copay (1 per six months). Routine 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. 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* \$15 copay Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs*†		
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 Skilled Nursing Facility* Physical Therapy* Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs*1 Routine Visit: \$0 copay (1 per year). So copay (1 per yea	Hearing Services	Routine: \$45 copay (1 Per Year). TruHearing Advanced: \$599 copay;
\$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* Physical Therapy* Ambulance (per oneway trip)* \$15 copay Ambulance (per oneway trip)* Transportation Not Covered Medicare Part B Drugs*† Not Covered	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 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 \$\text{Skilled Nursing Facility*} \text{ \$0 copay/day (days 1-20), \$214 copay/day (days 21-100)} Physical Therapy* Ambulance (per one-way trip)* \$\text{Transportation} \text{Not Covered} Medicare Part B Drugs** Drugs** Inpatient: Days 1 - 6: \$260 copay per admit & Days 7 - 90: \$0 copay per admit*; \$1,560 OOP Max per year; Outpatient: \$40 copay \$\text{\$0 copay/day (days 21-100)} Solution: \$\$0 copay	Vision Services	
Facility* Physical Therapy* \$15 copay Ambulance (per oneway trip)* Transportation Medicare Part B Drugs* [†] Not Covered		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 Medicare Part B Drugs*† \$200 copay Not Covered 20% coinsurance		\$0 copay/day (days 1-20), \$214 copay/day (days 21-100)
way trip)* Transportation Not Covered Medicare Part B Drugs* [†] 20% coinsurance	Physical Therapy*	\$15 copay
Medicare Part B Drugs*† 20% coinsurance		\$200 copay
Drugs* [†]	Transportation	Not Covered
0.70		20% coinsurance
\$25 allowance once per quarter	OTC	\$25 allowance once per quarter
Flex Card Not Covered	Flex Card	
Durable Medical 20% coinsurance Equipment* \$0 copay for compression stockings, diabetic shoes/inserts		
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.

Catastrophic Coverage

2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug) 5 (Specialty Tier) 1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	\$0 Copay \$36 Copay \$105 Copay 25% of the cost \$105 Copay 33% of the cost Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay \$105 Copay 25% of the cost \$105 Copay
r 3 (Preferred Insulin) r 3 (Preferred Brand) r 4 (Insulin) r 4 (Non-Preferred Drug) r 5 (Specialty Tier) r 1 (Preferred Generic) r 2 (Generic) r 3 (Preferred Insulin) r 3 (Preferred Brand) r 4 (Insulin) r 4 (Non-Preferred Drug)	\$35 Copay 25% of the cost \$35 Copay 33% of the cost 33% of the cost 31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	\$105 Copay 25% of the cost \$105 Copay 33% of the cost Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay \$105 Copay 25% of the cost
3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug) 5 (Specialty Tier) 1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	25% of the cost \$35 Copay 33% of the cost 33% of the cost 31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	25% of the cost \$105 Copay 33% of the cost Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay 25% of the cost
2 4 (Insulin) 2 4 (Non-Preferred Drug) 2 5 (Specialty Tier) 3 1 (Preferred Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	\$35 Copay 33% of the cost 33% of the cost 31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	\$105 Copay 33% of the cost Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay \$105 Copay
4 (Non-Preferred Drug) 5 (Specialty Tier) 1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 4 (Insulin) 4 (Non-Preferred Drug)	33% of the cost 33% of the cost 31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	33% of the cost Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay 25% of the cost
1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	33% of the cost 31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	Not Applicable 100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay 25% of the cost
1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	31 Day Supply \$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	100 Day (T1/2) 90 Day (T3/4) \$21 Copay \$51 Copay \$105 Copay 25% of the cost
1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	\$7 Copay \$17 Copay \$35 Copay 25% of the cost \$35 Copay	\$21 Copay \$51 Copay \$105 Copay 25% of the cost
2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	\$17 Copay \$35 Copay 25% of the cost \$35 Copay	\$51 Copay \$105 Copay 25% of the cost
3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	\$35 Copay 25% of the cost \$35 Copay	\$105 Copay 25% of the cost
3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug)	25% of the cost \$35 Copay	25% of the cost
4 (Insulin) 4 (Non-Preferred Drug)	\$35 Copay	
4 (Non-Preferred Drug)	1 ,	\$105 Copay
` -	220/ 6:1	1 2
7 (C ' 1, T')	33% of the cost	33% of the cost
5 (Specialty Tier)	33% of the cost	Not Applicable
r	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
1 (Preferred Generic)	Not Applicable	\$0 Copay
2 (Generic)	Not Applicable	\$30 Copay
3 (Preferred Insulin)	Not Applicable	\$105 Copay
3 (Preferred Brand)	Not Applicable	25% of the cost
4 (Insulin)	Not Applicable	\$105 Copay
4 (Non-Preferred Drug)	Not Applicable	33% of the cost
5 (Specialty Tier)	33% of the cost	Not Applicable
r	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
	Not Applicable	\$17.50 Copay
2 (Generic)	Not Applicable	\$42.50 Copay
3 (Preferred Insulin)	Not Applicable	\$105 Copay
3 (Preferred Brand)	Not Applicable	25% of the cost
4 (Insulin)	Not Applicable	\$105 Copay
4 (Non-Preferred Drug)	Not Applicable	33% of the cost
5 (Specialty Tier)	33% of the cost	Not Applicable
	2 (Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug) 5 (Specialty Tier) 1 (Preferred Generic) 2 (Generic) 3 (Preferred Insulin) 3 (Preferred Brand) 4 (Insulin) 4 (Non-Preferred Drug) 5 (Specialty Tier) t-of-pocket drug costs (including	1 (Preferred Generic) Not Applicable 2 (Generic) Not Applicable 3 (Preferred Insulin) Not Applicable 4 (Insulin) Not Applicable 4 (Non-Preferred Drug) Not Applicable 5 (Specialty Tier) 1 (Preferred Generic) Not Applicable 2 (Generic) Not Applicable 3 (Preferred Insulin) Not Applicable 3 (Preferred Insulin) Not Applicable 3 (Preferred Brand) Not Applicable 4 (Insulin) Not Applicable 4 (Insulin) Not Applicable Not Applicable Not Applicable

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

You pay the following until your total yearly drug costs reach \$2,0	00.
--	-----

Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	\$0			
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
	Retail	Tier 2 (Generic)	\$2 Copay	\$6 Copay
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay
	Sharing	Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	\$35 Copay	\$105 Copay
		Tier 4 (Non-Preferred Drug)	50% of the cost	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)	\$5 Copay	\$15 Copay
	Retail	Tier 2 (Generic)	\$17 Copay	\$51 Copay
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay
	Sharing	Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
Initial Coverage		Tier 4 (Insulin)	\$35 Copay	\$105 Copay
		Tier 4 (Non-Preferred Drug)	50% of the cost	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
	Preferred Mail	Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
	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
Catastrophic Coverage		\\1	ling drugs purchased through you	ur retail pharmacy and through mail order)

You pay the following	بيميد انهمييي	+0+0		to rooch (**) 000
YOU DAV IDE IOIIOWIDG	1 1 11 11 11 17 (1)	ir iolai vean	iv anna cas	is reach az odo
	a arren voc		I W GI GG GGG	10 100011 WZ,000.

Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4
	D., 6,	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
	Preferred Retail	Tier 2 (Generic)	\$10 Copay	\$30 Copay
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay
	Sharing	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
Initial Coverage		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
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4
	Preferred Mail Cost- Sharing	Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay
		Tier 2 (Generic)	Not Applicable	\$25 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	\$105 Copay
		Tier 4 (Insulin)	Not Applicable	\$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$235 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	\$17.50 Copay
		Tier 2 (Generic)	Not Applicable	\$37.50 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	\$117.50 Copay
		Tier 4 (Insulin)	Not Applicable	\$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	\$250 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

You pay the following until your total yearly drug costs reach \$2,000.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	\$0			
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay
	Retail	Tier 2 (Generic)	\$10 Copay	\$30 Copay
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay
	Sharing	Tier 3 (Preferred Brand)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	\$35 Copay	\$105 Copay
		Tier 4 (Non-Preferred Drug)	40% of the cost	40% 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)	\$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)	25% of the cost	25% of the cost
		Tier 4 (Insulin)	\$35 Copay	\$105 Copay
		Tier 4 (Non-Preferred Drug)	40% of the cost	40% of the cost
Initial Coverage		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
	Preferred Mail Cost-	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	\$25 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	40% 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	\$17.50 Copay
	Mail Cost- Sharing	Tier 2 (Generic)	Not Applicable	\$37.50 Copay
		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	40% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable



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.