HIGHMARK

Western New York

Community Blue Medicare HMO

Summary of Benefits

January 1, 2026 to December 31, 2026

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:

Genesee, 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 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.

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	Community Blue Medicare HMO Signature (HMO)	Community Blue Medicare HMO Distinct (HMO)
Premium	$0	$59
Part B Premium Reduction	$2	$0
Deductible	$0	$0
Max Out-Of-Pocket	$6,750	$6,750
Inpatient Hospital Stay*	Days 1 - 6: $400 copay per day per admit & Days 7 - 90: $0 copay per admit	Days 1 - 6: $345 copay per day per admit & Days 7 - 90: $0 copay per admit
Outpatient Hospital Coverage*	ASC[1]: $350 copay Facility: $450 copay	ASC[1]: $300 copay Facility: $400 copay
Doctor Office Visit	PCP: $0 copay Specialist: $55 copay	PCP: $0 copay 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 Office/Outpatient: $10 copay	Freestanding Lab: $0 copay Office/Outpatient: $10 copay
X-Rays*/ Advanced Imaging*	X-ray: $45 copay Advanced Imaging: $300 copay	X-ray: $45 copay Advanced Imaging: $225 copay
Hearing Services	Medicare Covered: $55 copay. Routine: $45 copay (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year); TruHearing Premium: $999 copay (2 Aids Every Year)	Medicare Covered: $35 copay. Routine: $35 copay (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year); TruHearing Premium: $999 copay (2 Aids Every Year)
Dental Services	Medicare Covered: $55 copay. Routine Office Visit: $0 copay (2 per year). Routine X-rays: $0 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: $35 copay. Routine Office Visit: $0 copay (2 per year). Routine X-rays: $0 copay (1 per year). Comprehensive 50% coinsurance with a maximum $2,000 allowance (comprehensive) (per year). See the EOC for full benefits.
Vision Services	Medicare Covered: $55 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.	Medicare Covered: $35 copay. $0 diabetic retinal eye exam. Routine: $10 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $200 annual eyewear allowance.
Mental Health Services	Inpatient: Days 1 - 4: $405 copay per day per admit & Days 5 - 90: $0 copay per admit*; $1,620 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), $218 copay/day (days 21 - 100)	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100)
Physical Therapy	$35 copay	$25 copay
Ambulance (per one-way trip)*	$390 copay	$395 copay
Transportation	Not Covered	Not Covered
Medicare Part B Drugs*†	20% coinsurance	20% coinsurance
OTC	$75 allowance once per quarter	$50 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.

ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Community Blue Medicare HMO Signature (HMO)

DRUG

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)	$3 Copay	$9 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)	$5 Copay	$15 Copay
		Tier 2 (Generic)	$20 Copay	$60 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	$7 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	$15 Copay
		Tier 2 (Generic)	Not Applicable	$60 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)

DRUG

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)	$3 Copay	$9 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	$7 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 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.

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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.

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