January 1, 2027 to December 31, 2027

Complete Blue Plus PPO Merit (PPO) Summary of Benefits

Northeastern Pennsylvania

This summary of benefits doesn't list every service, limitation, or special circumstance. Visit **medicare.highmark.com** to view the plan's Evidence of Coverage (EOC), which includes a complete list of covered services. Premium, deductible and limits are the amounts you pay for covered services.

For more information 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.

You can enroll in this plan if you:

- Have Medicare Part A
- Are enrolled in Medicare Part B
- Live in one of the following counties: Clinton, Lycoming, or Sullivan.



Complete Blue Plus PPO Merit (PPO)	
Monthly plan premium	$0
Part B premium reduction	$111
Medical deductible	$500
Maximum out-of-pocket for in-/out-of-network services	$8,500 / $14,800

Covered Medical and Hospital Benefits	In-Network	Out-of-Network
Inpatient hospital admit stays*		
Days 1 – 5, per day	$410	$600
Days 6 – 90, per day	$0	$0
Outpatient hospital visits*	$0-$425	$475
Ambulatory surgical center (ASC)*	$0-$375	$475
Office visits		
Primary care physician (PCP)	$0	40%
Specialist	$50	40%
Preventive Screenings (Office visit copay may apply)	$0	$0
Emergency room visit	$115	$115
Urgent care visit	$40	$40
Diagnostics and laboratory tests*		
Freestanding labs*	$0	40%
Physician office*	$0	40%
Outpatient facility*	$10/$40	40%
X-rays/advanced imaging*		
X-rays*	$20	40%
Advanced imaging*	$300	40%
Hearing		
Medicare-covered services	$50	40%
Yearly routine exam	$20	$20
TruHearing™ (1 aid per ear per year)		
Advanced (One-time use in-network)	$699	-
Premium (One-time use in-network)	$999	-
Yearly allowance (Every year in- or out-of-network)	$500	$500
Dental		
Medicare-covered services	$50	40%
Bi-annual routine cleaning and exam	$0	30%
Yearly routine X-rays	$0	30%
Comprehensive services	50%	50%
Combined max yearly allowance	$1,500	-
Vision		
Medicare-covered services	$0-$50	40%
Medicare-covered diabetic retinal eye exam	$0	40%
Yearly routine exam	$0	$50
Combined post-cataract surgery eyewear/contacts	$200	$200
Combined yearly routine eyewear allowance	$200	-
Mental health*		
Inpatient stays		
Days 1 – 5, per day	$400	$475
Days 6 – 90, per day	$0	$0
Outpatient visits*	$40	40%

Additional Covered Benefits	In-Network	Out-of-Network
Skilled nursing facility (SNF) admit stays*		
Days 1 – 20, per day	$0	30%
Days 21 – 100, per day	$221	30%
Physical therapy*	$50	40%
One-way emergency/non-emergency ambulance trip*	$310	$310 / 30%
Medicare Part B drugs^*	0 - 20%	30%
Formulary	Performance	

Formulary Benefits

Deductible: Tier 1-2: $0, Tier 3, Tier 4 and Tier 5: $700

You pay the following until your total yearly drug costs reach $2,400.

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

	Initial Coverage	Preferred Retail			Standard Retail			Preferred Mail			Standard Mail		
DRUGS	**Days Supply**	**31**	**90**	**100**	**31**	**90**	**100**	**31**	**90**	**100**	**31**	**90**	**100**
	Tier 1	$0	-	$0	$7	-	$21	-	-	$0	-	-	$21
	Tier 2	$0	-	$0	$15	-	$45	-	-	$0	-	-	$45
	Tier 3	23%	23%	-	23%	23%	-	-	23%	-	-	23%	-
	Tier 4	25%	25%	-	25%	25%	-	-	25%	-	-	25%	-
	Tier 5	25%	-	-	25%	-	-	25%	-	-	25%	-	-

	Initial Coverage	Preferred Retail			Standard Retail			Preferred Mail			Standard Mail		
INSULIN	**Days Supply**	**31**	**90**	**100**	**31**	**90**	**100**	**31**	**90**	**100**	**31**	**90**	**100**
	Tier 3	$35	$105	-	$35	$105	-	-	$105	-	-	$105	-
	Tier 4	$35	$105	-	$35	$105	-	-	$105	-	-	$105	-

Catastrophic Coverage: After your yearly OOP drug costs (including drugs purchased through your retail pharmacy and mail order) reach $2,400, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

**Service requires prior authorization.*

^Certain rebatable drugs may have a lower coinsurance. Insulin has a copayment cap of $35 for one-month's supply.

Certain procedures, services, and drugs may need advance approval or prior authorization. Please refer to your EOC.

Questions? We're here to help!

Already a member or need a copy of the EOC?
Call us at **1-833-227-9375** (TTY: 711), seven days a week, 8 a.m. to 8 p.m. ET.

Looking to enroll for the first time?

Talk with a local **Licensed Highmark Medicare advisor,** visit a **Highmark Direct store or Medicare center,** or call **1-866-746-7971** (TTY: 711)

October 1 – March 31: 8 a.m. to 8 p.m. ET, 7 days a week
April 1 – September 30: 8 a.m. to 8 p.m. ET, Monday–Friday

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.

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.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. 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.



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