Capital

2027 Summary of Benefits

Capital Blue Cross Select (PPO)

H3923, Plan 044

January 1, 2027 - December 31, 2027

Capital Blue Cross Select (PPO) is a Medicare Advantage PPO plan (PPO stands for Preferred Provider Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Member Services at 866-987-4213 (TTY: 711). Hours are Monday - Friday, 8:00 AM - 8:00 PM ET, with extended hours October 1 - March 31. After these hours, you may leave a message on our secure voice messaging system and request the *Evidence of Coverage* or access it online at CapitalBlueMedicare.com.

Please contact our sales team number at 800-990-4201 for additional information. (TTY: 711.) Calls to this number are free. Hours are Monday through Friday, 8:00 AM to 6:00 PM ET, with extended hours October 1 through December 7. After these hours, you may leave a message on our secure voice messaging system. You may also visit the website at CapitalBlueMedicare.com.

To join Capital Blue Cross Select (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes these counties in Pennsylvania: Cumberland, Fulton, Lancaster, and Lebanon.

Capital Blue Cross Select (PPO) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at CapitalBlueMedicare.com. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for these services.

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 get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

	Capital Blue Cross Select (PPO)
Monthly Plan Premium *(includes both medical and drugs)*	$0
Deductible	No deductible for medical. See prescription drug coverage for Part D deductible.
Maximum out-of-pocket amount	From network providers: $9,850 From network and out-of-network providers combined: $9,850
Inpatient Hospital coverage	**In-Network** $345 copayment each day for days 1 to 6 and $0 copayment each day for days 7 to 90 for Medicare-covered hospital care. *Prior Authorization is required.* **Out-of-Network** $345 copayment each day for days 1 to 6 for Medicare-covered hospital care.
Outpatient Hospital coverage Outpatient hospital services	**In-Network** $0 - $500 copayment *Prior Authorization is required.* **Out-of-Network** 30% coinsurance
Ambulatory Surgical Center (ASC)	**In-Network** $0 - $375 copayment *Prior Authorization is required.* **Out-of-Network** 30% coinsurance

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Doctor Visits	
Primary Care Providers	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Specialists	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network** $0 copayment **Out-of-Network** $0 copayment
Emergency care	$115 copayment
Urgently needed services	$40 copayment
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	**In-Network** $0 copayment *Prior Authorization is required.* **Out-of-Network** 30% coinsurance
Lab services	**In-Network** $0 - $100 copayment *Prior Authorization is required.* **Out-of-Network** 30% coinsurance

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Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** $0 - $350 copayment *Prior Authorization is required.* **Out-of-Network** 30% coinsurance
Outpatient X-rays	**In-Network** $30 copayment **Out-of-Network** 30% coinsurance
Therapeutic Radiology	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 30% coinsurance
Hearing services	
Routine hearing exam	**In-Network** $0 copayment Limited to 1 visit(s) every year **Out-of-Network** 90% coinsurance
Fitting-evaluation(s) for hearing aids	**In-Network** $0 copayment **Out-of-Network** 90% coinsurance
Prescription Hearing aids	
All types	**In-Network** $499 - $999 copayment Limited to 2 hearing aid(s) every year **Out-of-Network** 90% coinsurance

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Dental services	Up to a $2,500 combined allowance every year for in-network and out-of-network preventive and comprehensive dental services.
Preventive dental services	**In-Network** $0 copayment **Out-of-Network** 60% coinsurance
Comprehensive dental services	**In-Network** 50% coinsurance **Out-of-Network** 60% coinsurance
Vision care	
Routine eye exam	**In-Network** $0 copayment Limited to 1 visit(s) every year **Out-of-Network** 50% coinsurance
Additional routine eyewear including eyeglasses (frames and lenses) or contact lenses	Up to a $125 allowance per year for one pair of eyeglasses (frames and lenses) or contact lenses combined in-network and out-of-network.

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Mental Health Services	
Inpatient visit	**In-Network** $345 copayment each day for days 1 to 6 and $0 copayment each day for days 7 to 90 for Medicare-covered hospital care. *Prior Authorization is required.* **Out-of-Network** $345 copayment each day for days 1 to 6 and $0 copayment each day for days 7 to 90 for Medicare-covered hospital care.
Outpatient group therapy visit	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Outpatient individual therapy visit	**In-Network** $35 copayment **Out-of-Network** $35 copayment
Skilled nursing facility (SNF) care	**In-Network** $0 copayment each day for days 1 to 20 and $221 copayment each day for days 21 to 100 for Medicare-covered skilled nursing facility care. *Prior Authorization is required.* **Out-of-Network** $0 copayment each day for days 1 to 20 and $221 copayment each day for days 21 to 100 for Medicare-covered skilled nursing facility care.

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Ambulance services	
Ground Ambulance	**In-Network** $370 copayment **Out-of-Network** $370 copayment
Air Ambulance	**In-Network** $370 copayment *Prior Authorization is required.* **Out-of-Network** $370 copayment
Medicare Part B drugs	
Chemotherapy/Radiation drugs	**In-Network** 0% - 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 0% - 20% coinsurance
Other Part B drugs	**In-Network** 0% - 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 0% - 20% coinsurance

Additional Benefits

	Capital Blue Cross Select (PPO)
Durable medical equipment (DME) and related supplies	**In-Network** 20% coinsurance *Prior Authorization is required.* **Out-of-Network** 20% coinsurance
Fitness program	**In-Network** $0 copayment Coverage includes: Physical Fitness **Out-of-Network** 90% coinsurance
Outpatient rehabilitation services Services provided by an occupational therapist, physical therapist, or speech therapist	**In-Network** $30 copayment **Out-of-Network** $30 copayment
Over-the-counter benefit	**In-Network** $0 copayment You are eligible for a $30 combined quarterly allowance to be used toward the purchase of in-network and out-of-network over-the-counter (OTC) health and wellness products. **Out-of-Network** 90% coinsurance

Prescription Drug Coverage	Capital Blue Cross Select (PPO)	
Stage 1: Annual Prescription Deductible		
Deductible	$700 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.	
Stage 2: Initial Coverage		
Retail and mail-order cost-sharing (30-day supply)		
	Preferred	**Standard**
Tier 1 (Preferred Generic)	$0 copayment	$10 copayment
Tier 2 (Generic)	$0 copayment	$15 copayment
Tier 3 (Preferred Brand)	19% coinsurance	19% coinsurance
Tier 4 (Non-Preferred Drug)	20% coinsurance	20% coinsurance
Tier 5 (Specialty Tier)	25% coinsurance	25% coinsurance
Stage 3: Catastrophic Coverage		
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay nothing.	

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (30-day supply) or long term (100-day supply).

- Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.
- You pay 25% of the total cost up to $35 max copay per month supply of each covered insulin product even if you haven’t paid your deductible.

DISCLAIMERS

This document is available in alternate formats.

Capital Blue Cross is an HMO, PPO Plan with a Medicare Contract. Enrollment in Capital Blue Cross depends on contract renewal. Capital Blue Cross is an independent licensee of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

Health coverage is offered by Capital Advantage Insurance Company®, a subsidiary of Capital Blue Cross.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Capital Blue Cross members, except in emergency situations. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

You must continue to pay your Medicare Part B premium.

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