

# 2027 Summary of Benefits

Capital Blue Cross Enhanced (PPO)

H3923, Plan 046

January 1, 2027 - December 31, 2027

**Capital Blue Cross Enhanced (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 Enhanced (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: Columbia, Montour, Northumberland, Snyder, and Union.

Capital Blue Cross Enhanced (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 Enhanced (PPO)** |
|---|---|
| **Monthly Plan Premium** *(includes both medical and drugs)* | $36 |
| **Deductible** | No deductible for medical. See prescription drug coverage for Part D deductible. |
| **Maximum out-of-pocket amount** | From network providers: $7,150<br>From network and out-of-network providers combined: $7,150 |
| **Inpatient Hospital coverage** | **In-Network**<br>$265 copayment each day for days 1 to 6 and $0 copayment each day for days 7 to 90 for Medicare-covered hospital care.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>$265 copayment each day for days 1 to 6 for Medicare-covered hospital care. |
| **Outpatient Hospital coverage**<br>Outpatient hospital services | **In-Network**<br>$0 - $500 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |
| **Ambulatory Surgical Center (ASC)** | **In-Network**<br>$0 - $400 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |

| | **Capital Blue Cross Enhanced (PPO)** |
|---|---|
| **Doctor Visits** | |
| Primary Care Providers | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>$0 copayment |
| Specialists | **In-Network**<br>$20 copayment<br><br>**Out-of-Network**<br>$20 copayment |
| **Preventive Care (e.g., flu vaccine, diabetic screenings)** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>$0 copayment |
| **Emergency care** | $130 copayment |
| **Urgently needed services** | $40 copayment |
| **Diagnostic Services/Labs/Imaging** | |
| Diagnostic tests and procedures | **In-Network**<br>$0 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |
| Lab services | **In-Network**<br>$0 - $100 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |

| | Capital Blue Cross Enhanced (PPO) |
|---|---|
| Diagnostic radiology services (e.g. MRI, CAT Scan) | **In-Network**<br>$0 - $350 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |
| Outpatient X-rays | **In-Network**<br>$5 copayment<br><br>**Out-of-Network**<br>30% coinsurance |
| Therapeutic Radiology | **In-Network**<br>20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance |
| **Hearing services** | |
| Routine hearing exam | **In-Network**<br>$0 copayment<br>Limited to 1 visit(s) every year<br><br>**Out-of-Network**<br>90% coinsurance |
| Fitting-evaluation(s) for hearing aids | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>90% coinsurance |
| **Prescription Hearing aids** | |
| All types | **In-Network**<br>$499 - $999 copayment<br>Limited to 2 hearing aid(s) every year<br><br>**Out-of-Network**<br>90% coinsurance |

| | **Capital Blue Cross Enhanced (PPO)** |
|---|---|
| **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**<br>$0 copayment<br><br>**Out-of-Network**<br>60% coinsurance |
| Comprehensive dental services | **In-Network**<br>50% coinsurance<br><br>**Out-of-Network**<br>60% coinsurance |
| **Vision care** | |
| Routine eye exam | **In-Network**<br>$0 copayment<br>Limited to 1 visit(s) every year<br><br>**Out-of-Network**<br>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**<br>$265 copayment each day for days 1 to 6 and $0 copayment each day for days 7 to 90 for Medicare-covered hospital care.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>$265 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**<br>$20 copayment<br><br>**Out-of-Network**<br>$20 copayment |
| Outpatient individual therapy visit | **In-Network**<br>$20 copayment<br><br>**Out-of-Network**<br>$20 copayment |
| **Skilled nursing facility (SNF) care** | **In-Network**<br>$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.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>$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. |

| | **Capital Blue Cross Enhanced (PPO)** |
|---|---|
| **Ambulance services** | |
| Ground Ambulance | **In-Network**<br>$125 copayment<br><br>**Out-of-Network**<br>$125 copayment |
| Air Ambulance | **In-Network**<br>$125 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>$125 copayment |
| **Medicare Part B drugs** | |
| Chemotherapy/Radiation drugs | **In-Network**<br>0% - 20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>0% - 20% coinsurance |
| Other Part B drugs | **In-Network**<br>0% - 20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>0% - 20% coinsurance |

## Additional Benefits

| | **Capital Blue Cross Enhanced (PPO)** |
|---|---|
| **Durable medical equipment (DME) and related supplies** | **In-Network**<br>20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>20% coinsurance |
| **Fitness program** | **In-Network**<br>$0 copayment<br>Coverage includes: Physical Fitness<br><br>**Out-of-Network**<br>90% coinsurance |
| **Outpatient rehabilitation services**<br>Services provided by an occupational therapist, physical therapist, or speech therapist | **In-Network**<br>$15 copayment<br><br>**Out-of-Network**<br>$15 copayment |
| **Over-the-counter benefit** | **In-Network**<br>$0 copayment<br>You are eligible for a $25 combined quarterly allowance to be used toward the purchase of in-network and out-of-network over-the-counter (OTC) health and wellness products.<br><br>**Out-of-Network**<br>90% coinsurance |

| Prescription Drug Coverage | Capital Blue Cross Enhanced (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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