January 1, 2027 to December 31, 2027

Community Blue Medicare HMO Signature (HMO)

Summary of Benefits

Western 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: Blair, Cambria, Clarion, Greene, Jefferson, or Somerset.



Community Blue Medicare HMO Signature (HMO)	
Monthly plan premium	$0
Part B premium reduction	$0
Medical deductible	$0
Maximum out-of-pocket for in-network services	$6,950

Covered Medical and Hospital Benefits	In-Network	Out-of-Network
Inpatient hospital admit stays*		
Days 1 – 5, per day	$295	Not covered
Days 6 – 90, per day	$0	Not covered
Outpatient hospital visits*	$0-$375	Not covered
Ambulatory surgical center (ASC)*	$0-$325	Not covered
Office visits		
Primary care physician (PCP)	$0	Not covered
Specialist	$35	Not covered
Preventive Screenings (Office visit copay may apply)	$0	Not covered
Emergency room visit	$130	Not covered
Urgent care visit	$40	Not covered
Diagnostics and laboratory tests*		
Freestanding labs*	$0	Not covered
Physician office*	$0	Not covered
Outpatient facility*	$10/$20	Not covered
X-rays/advanced imaging*		
X-rays*	$20	Not covered
Advanced imaging*	$325	Not covered
Hearing		
Medicare-covered services	$35	Not covered
Yearly routine exam	$10	Not covered
TruHearing™ (1 aid per ear per year)		
Advanced (Every year in-network)	$699	Not covered
Premium (Every year in-network)	$999	Not covered
Dental		
Medicare-covered services	$35	Not covered
Bi-annual routine cleaning and exam	$0	Not covered
Yearly routine X-rays	$0	Not covered
Comprehensive services	20%	Not covered
Combined max yearly allowance	$1,500	Not covered
Vision		
Medicare-covered services	$0-$35	Not covered
Medicare-covered diabetic retinal eye exam	$0	Not covered
Yearly routine exam	$0	Not covered
Combined post-cataract surgery eyewear/contacts	$200	Not covered
Combined yearly routine eyewear allowance	$200	Not covered
Mental health*		
Inpatient stays		
Days 1 – 3, per day	$425	Not covered
Days 4 – 90, per day	$0	Not covered
Outpatient visits*	$40	Not covered

Additional Covered Benefits	In-Network	Out-of-Network
Skilled nursing facility (SNF) admit stays*		
Days 1 – 20, per day	$0	Not covered
Days 21 – 100, per day	$221	Not covered
Physical therapy*	$30	Not covered
One-way emergency/non-emergency ambulance trip*	$280	Not covered
Medicare Part B drugs^*	0 - 20%	Not covered
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.

DRUGS	Initial Coverage	Preferred Retail			Standard Retail			Preferred Mail			Standard Mail		
	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	22%	22%	-	22%	22%	-	-	22%	-	-	22%	-
	Tier 4	25%	25%	-	25%	25%	-	-	25%	-	-	25%	-
	Tier 5	25%	-	-	25%	-	-	25%	-	-	25%	-	-

INSULIN	Initial Coverage	Preferred Retail			Standard Retail			Preferred Mail			Standard Mail		
	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 **1-888-234-5397** (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.

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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.

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



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