**January 1, 2027 to December 31, 2027**

# Complete Blue HMO Distinct (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.

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**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: Allegheny, Armstrong, Beaver, Butler, or Washington.

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| Complete Blue HMO Distinct (HMO) | |
|---|---|
| Monthly plan premium | $40 |
| Part B premium reduction | $0 |
| Medical deductible | $0 |
| Maximum out-of-pocket for in-network services | $6,450 |

| Covered Medical and Hospital Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Inpatient hospital admit stays*** | | |
| Per admit | $295 | Not covered |
| **Outpatient hospital visits*** | $0-$250 | Not covered |
| **Ambulatory surgical center (ASC)*** | $0-$200 | Not covered |
| **Office visits** | | |
| Primary care physician (PCP) | $0 | Not covered |
| Specialist | $20 | 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 | Not covered |
| **X-rays/advanced imaging*** | | |
| X-rays* | $20 | Not covered |
| Advanced imaging* | $225 | Not covered |
| **Hearing** | | |
| Medicare-covered services | $20 | 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 | $20 | Not covered |
| Bi-annual routine cleaning and exam | $0 | Not covered |
| Yearly routine X-rays | $0 | Not covered |
| Comprehensive services | $0 | Not covered |
| Combined max yearly allowance | $2,500 | Not covered |
| **Vision** | | |
| Medicare-covered services | $0-$20 | 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 | | |
| Per Admit | $225 | Not covered |
| Outpatient visits* | $30 | 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*** | $20 | Not covered |
| **One-way emergency/non-emergency ambulance trip*** | $275 | 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** | 21% | 21% | - | 21% | 21% | - | - | 21% | - | - | 21% | - |
| | **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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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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