2021 Benefit Summary

		Western PA Annual Conference of the United Methodist Church	178471 Freedom Blue PPO Premium Option	178470 Freedom Blue PPO Standard Option	584541 Community Blue Medicare HMO
HEALTH		Deductible	$0	$0	$0
			In Network/Out of Network	**In Network/Out of Network**	**In Network**
		Out-of-Pocket Maximum	$3,400 / $3,400	$3,400 / $3,400	$3,400
		Annual Physical Exam	Covered in Full	Covered in Full	Covered in Full
		Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full	Covered in Full
		Doctor Office Visit	$15 / $15	$15 / $15	$15
		Specialist Office Visit	$20 / $20	$15 / $15	$15
		X-ray or Radiology	0% / 0%	0% / 0%	0%
		Diagnostic Testing	0% / 0%	0% / 0%	0%
		Outpatient Surgery	$0 / $0	0% / 0%	0%
		Emergency Room Services (Worldwide Coverage)	$50	$50	$50

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		Urgently Needed Care (this is NOT emergency care)	$40	$40	$40
		Inpatient Hospital Stay	$0 / $0 per stay	0% / 0% per stay	0% per stay
		Skilled Nursing Facility Care (100 days per Medicare benefit period)	$0 / $0	$0 / $0	0% per day
		Annual Routine Vision Exam (Includes refraction)	$0 / $50 copay for eye exam	$0 / $50 copay for eye exam	$0 for eye exam
		Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses. / $150 benefit maximum	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses./ $150 benefit maximum	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses.
		Annual Routine Hearing Exam	$20 / $20	$15 / $15	$15
		Hearing Aids	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing / $500 allowance for hearing aids every 3 years from any other provider	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing / $500 allowance for hearing aids every 3 years from any other provider	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium

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		Home Health	$0 / $0	0% / 0%	0%
		Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$20 / $20	$15 / $15	$15
		Part B Drugs	10% up to $300 Qtr max / 10% up to $300 Qtr max	10% up to $300 Qtr max / 10% up to $300 Qtr max	10% up to $300 Qtr max
		Ambulance (Emergent Services per one way trip)	$25	$25	$25
		Ambulance (Non-Emergent) Services per one way trip	$25 / 20%	$25 / 20%	$25
		Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	15% / 20%	15% / 20%	15%
		Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	$0 / $0 per stay	$0 / $0 per stay	0% per stay
		Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$20 / $20	$15 / $15	$15

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DRUGS	PART D DRUGS UP TO 31 DAY RETAIL SUPPLY	Initial Coverage Period – Preferred Pharmacy (up to $4,130 in total drug costs)	$10 Pref. Generic $10 Generic $25 Preferred Brand $55 Non-Pref. Brand 33% Specialty	$10 Pref. Generic $10 Generic $25 Preferred Brand $55 Non-Pref. Brand $60 Specialty	$10 Pref. Generic $10 Generic $25 Preferred Brand $55 Non-Pref. Brand $60 Specialty
		Initial Coverage Period – Standard Pharmacy (up to $4,130 in total drug costs)	$15 Pref. Generic $15 Generic $30 Preferred Brand $60 Non-Pref. Brand 33% Specialty	$15 Pref. Generic $15 Generic $30 Preferred Brand $60 Non-Pref. Brand $60 Specialty	$15 Pref. Generic $15 Generic $30 Preferred Brand $60 Non-Pref. Brand $60 Specialty
		Coverage Gap Period – Preferred Pharmacy (from $4,130 in total drug costs to $6,550 in yearly out-of-pocket drug costs)	$10 Pref. Generic $10 Generic $25 Preferred Brand $55 Non-Pref. Brand 33% Specialty	$10 Pref. Generic $10 Generic 20% Preferred Brand 20% Non-Pref. Brand 25% Specialty	$10 Pref. Generic $10 Generic 20% Preferred Brand 20% Non-Pref. Brand 25% Specialty
		Coverage Gap Period – Standard Pharmacy (from $4,130 in total drug costs to $6,550 in yearly out-of-pocket drug costs)	$15 Pref. Generic $15 Generic $30 Preferred Brand $60 Non-Pref. Brand 33% Specialty	$15 Pref. Generic $15 Generic 25% Preferred Brand 25% Non-Pref. Brand 25% Specialty	$15 Pref. Generic $15 Generic 25% Preferred Brand 25% Non-Pref. Brand 25% Specialty
		Catastrophic Coverage Period (after $6,550 in total out-of-pocket drug costs)	$10 for all covered Part D drugs	The greater of 5% or $3.60 for generic or multi-source drugs or $8.95 for all other drugs	The greater of 5% or $3.60 for generic or multi-source drugs or $8.95 for all other drugs
		Mail Order (up to 90-day supply, Specialty Drug up to 31-day supply)	2.5 times preferred pharmacy retail copay	2.5 times preferred pharmacy retail copay	2.5 times preferred pharmacy retail copay

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

Highmark Choice Company and Highmark Senior Health Company are Medicare Advantage plans with a Medicare contract. Enrollment in Highmark Choice Company and Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield, Highmark Choice Company, and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association. Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, you may wish to consider our Freedom Blue PPO Medicare Advantage product.Community Blue Medicare HMO is a limited network plan. If you want access to Highmark's full provider network, including UPMC hospitals and physicians, you may wish to consider our Security Blue HMO-POS and Freedom Blue PPO Medicare Advantage Products. Please verify that your providers are participating before enrolling. If a provider does not participate, neither Medicare nor Community Blue Medicare HMO will be responsible for the costs. Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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. TruHearing is a registered trademark of TruHearing, Inc. This information is not a complete description of benefits. Contact 1-866-456-7739 for more information. You must continue to pay your Medicare Part B premium.

*If you would like a printed copy of your EOC, please call Customer Service at the number on the back of your ID card or visit www.Medicare.Highmark.com.

Questions on Freedom Blue PPO or Community Blue Medicare HMO benefits? Call 1-866-456-7739 (TTY users call 711)
Reference Code (Please have this number ready when you call): **21FB178471** – Premium Option, **21FB178470** – Standard Option, and **21CB584541 –** Community Blue Medicare HMO

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

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