# BlueJourney PPO

## 2021 Summary of Benefits

BlueJourney Select | BlueJourney Prime | BlueJourney Classic

Capital BLUE MEDICARE

H3923_SOB01-21_M

# Summary of Benefits

January 1, 2021 — December 31, 2021

## Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **BlueJourney - Prime, Classic, and Select (PPO).**

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueJourney - Prime, Classic, and Select (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- 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 www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Sections in this booklet

- Things to Know About **BlueJourney - Prime, Classic, and Select (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-866-987-4213 (TTY 711).

## Things to Know About BlueJourney - Prime, Classic, and Select (PPO) Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

## BlueJourney – Prime, Classic, and Select (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-866-987-4213 (TTY 711).
- If you are not a member of this plan, call toll-free 1-800-990-4201 (TTY 711).
- Our website: CapitalBlueMedicare.com

**Who can join?**

To join **BlueJourney – Prime, Classic, and 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 the following counties in Pennsylvania: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

**Which doctors, hospitals, and pharmacies can I use?**

**BlueJourney – Prime, Classic, and Select (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. With our PPO plans, you can also use providers that are not in our network. **Our BlueJourney PPO plans provides predictable out-of-pocket costs for Out-of-Network medical services as most Out-of-Network costs are the same as In-Network, after the deductible has been met.**

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (CapitalBlueMedicare.com). Or, call us and we will send you a copy of the provider and pharmacy directory.

**What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more.*

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, CapitalBlueMedicare.com.
- Or, call us and we will send you a copy of the formulary.
- Cost sharing for deductible, the initial coverage phase, coverage gap, and catastrophic coverage. Cost sharing must be broken down by the tier number/name/ (e.g., Tier 1 generic).
- When applicable, a notation that costs may differ based on pharmacy type or status (e.g., preferred /non-preferred, mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply).

**How will I determine my drug costs?**

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

**Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.**

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at 1-866-987-4213, 8 a.m. to 8 p.m. 7 days a week, October 1 through March 31. April 1 through September 30, 8 a.m. to 8 p.m., Monday through Friday.

**Understanding the Benefits**

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit CapitalBlueMedicare.com or call 1-866-987-4213, 8 a.m. to 8 p.m. 7 days a week, October 1 through March 31. April 1 through September 30, 8 a.m. to 8 p.m., Monday through Friday, to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor or pay the Out-of-Network cost-sharing.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

**Understanding Important Rules**

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Monthly Plan Premium** | You pay $171 per month. | You pay $49 per month. | You pay $0 per month. |
| **Medicare Part B Premium** | You must continue to pay your Medicare Part B premium. Medicare Part B premiums and plan premiums do not apply to your maximum out-of-pocket limit. | | |
| **Deductible** | This plan has a deductible for some hospital and medical services.<br><br>**Out-of-Network:** You pay $250 deductible per year for Out-of-Network services. This plan does not have a deductible for Part D prescription drugs. | This plan has a deductible for some hospital and medical services.<br><br>**Out-of-Network:** You pay $350 deductible per year for Out-of-Network services. This plan does not have a deductible for Part D prescription drugs | This plan has a deductible for some hospital and medical services.<br><br>**Out-of-Network:** You pay $750 deductible per year for Out-of-Network services. This plan does not have a deductible for Part D prescription drugs |
| **Maximum Out-of-Pocket (MOOP) Responsibility** | **In-Network** $4,000 annually<br><br>**Combined In-and Out-of-Network** $6,000 annually | **In-Network** $6,700 annually<br><br>**Combined In-and Out-of-Network** $10,000 annually | **In-Network** $6,700 annually<br><br>**Combined In-and Out-of-Network** $10,000 annually |
| **Items that do not count towards your Maximum Out-of-Pocket Costs** | The amounts you pay for copayments, and coinsurance for in- and Out-of-Network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs **do not** count toward your maximum out-of-pocket amounts.<br><br>Additionally, there are other services that do not count towards your maximum out-of-pocket costs. These services include, routine eye exams and eyewear, preventive dental exams and comprehensive dental services, routine hearing exams and hearing aids, over-the-counter pharmacy items, SilverSneakers fitness benefit, health education services, nutritional/dietary services, post-discharge meals, in home support services, transportation, and fresh produce box, if applicable for your PPO plan. For a complete list of benefit excluded from the maximum out-of-pocket for your PPO plan, please refer to the Evidence of Coverage or contact the plan. | | |

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Items that do not count towards your Maximum Out-of-Pocket Costs *(continued)*** | If you reach this limit for your out-of-pocket costs, you continue receiving covered hospital and medical services and we will pay the full cost for the rest of the calendar year. | | |
| **Member Cost** | This section focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of BlueJourney PPO.<br><br>To understand the payment information, we give you in the benefit chart, you need to know about the types of out-of-pocket costs you may pay for your covered services.<br>• The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share.<br>• A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service.<br>• **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. | | |

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Inpatient Hospital Coverage** | **Prior authorization required.** | | |
| **Inpatient hospital** | **In-Network**<br>You pay:<br>$100 copay per day for days 1 through 6 per stay<br>$0 copay per day for days 7 and beyond per stay<br><br>Our plan covers an unlimited number of medically necessary days per hospital stay<br><br>Copays per day indicated above apply per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] | **In-Network**<br>You pay:<br>$225 copay per day for days 1 through 7 per stay<br>$0 copay per day for days 8 and beyond per stay<br><br>Our plan covers an unlimited number of medically necessary days per hospital stay<br><br>Copays per day indicated above apply per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] | **In-Network**<br>You pay:<br>$335 copay per stay<br><br>Our plan covers an unlimited number of medically necessary days per hospital stay<br><br>Copay per stay indicated above applies per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] |
| **Outpatient Hospital Coverage** | **Prior authorization may be required.** You pay applicable copay per ambulatory surgical center or outpatient hospital surgical visit. | | |
| **Ambulatory surgical center** | **In-Network:**<br>You pay a $125 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $225 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $300 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] |
| **Outpatient hospital** | **In-Network:**<br>You pay a $225 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $300 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $350 copay<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Doctor Visits** | Telehealth visits are covered at the office visit copay listed, if your network provider is able to offer telehealth as an alternative to face to face visits. | | |
| **Primary care provider (PCP)**<br><br>**Specialists** | **In-Network:**<br>You pay a $5 copay per PCP visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1]<br><br>**In-Network:**<br>You pay a $25 copay per specialist visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $5 copay per PCP visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1]<br><br>**In-Network:**<br>You pay a $30 copay per specialist visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] | **In-Network:**<br>You pay a $5 copay per PCP visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1]<br><br>**In-Network:**<br>You pay a $40 copay per specialist visit<br><br>**Out-of-Network:**<br>Same copay as In-Network[1] |
| **Preventive Care** | Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.<br><br>Telehealth visits are covered at the copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits for certain preventive care services. | | |
| **Abdominal aortic aneurysm screening** | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] |
| **Alcohol misuse counseling** | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] |
| **Bone mass measurement** | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] |

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| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Preventive Care** ***continued*** | Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.<br><br>Telehealth visits are covered at the copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits for certain preventive care services. | | |
| **Breast cancer screening (mammogram)** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Cardiovascular disease (behavioral therapy)** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Cardiovascular screenings** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Cervical and vaginal cancer screening** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Depression screening** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |

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| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Preventive Care** ***continued*** | Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.<br><br>Telehealth visits are covered at the copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits for certain preventive care services. | | |
| **Diabetes screenings** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **HIV screening** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Obesity screening and counseling** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Prostate cancer screenings (PSA)** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Sexually transmitted infections screening and counseling** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |
| **Tobacco use cessation counseling** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** 20% coinsurance[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Preventive Care** ***continued*** | Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.<br><br>Telehealth visits are covered at the copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits for certain preventive care services. | | |
| **Vaccines, including: flu shots, Hepatitis B shots, pneumococcal shots** | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] |
| **Welcome to Medicare preventive exam (one-time)** | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] |
| **Annual wellness exam** | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br>**Out-of-Network:** 20% coinsurance[1] |
| **Emergency Care** | If you are admitted to the hospital within 24 hours, your copay is waived. | | |
| | **In/Out-of-Network:** You pay a $90 copay per visit (within the U.S.) | **In/Out-of-Network:** You pay a $90 copay per visit (within the U.S.) | **In/Out-of-Network:** You pay a $90 copay per visit (within the U.S.) |
| **Worldwide Emergency Care** | Coverage of emergency services when outside the United States and its territories. Copay is waived if admitted to the hospital within 24 hours. Annual worldwide plan maximum is combined for emergency and urgent care. | | |
| | **In/Out-of-Network:** You pay a $90 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage | **In/Out-of-Network:** You pay a $90 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage | **In/Out-of-Network:** You pay a $90 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Urgently Needed Services** | Your copay is <u>not</u> waived if admitted to the hospital. | | |
| | **In/Out-of-Network:** You pay a $35 copay per visit (within the U.S.) | **In/Out-of-Network:** You pay a $45 copay per visit (within the U.S.) | **In/Out-of-Network:** You pay a $50 copay per visit (within the U.S.) |
| **Worldwide Urgent Care** | Coverage of urgent care services when outside the United States and its territories. Copay is <u>not</u> waived if admitted to the hospital. Annual worldwide plan maximum is combined for emergency and urgent care. | | |
| | **In/Out-of-Network:** You pay a $35 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage | **In/Out-of-Network:** You pay a $45 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage | **In/Out-of-Network:** You pay a $50 copay per visit (Worldwide – outside the U.S.)<br><br>$20,000 annual plan maximum coverage |
| **Diagnostic Services, Labs, Radiology Procedures, and X-rays** | **Prior authorization may be required.** Copay may vary depending on place of service. | | |
| **Lab services** | **In-Network:** You pay a $10 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $10 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $25 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Diagnostic tests and procedures** | **In-Network:** You pay a $10 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $15 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $25 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Outpatient x-rays** | **In-Network:** You pay a $20 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $25 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Diagnostic radiology services *(continued)*** | **May require prior authorization.** Copay may vary depending on place of service. | | |
| **Diagnostic radiology (CT, MRI)** | **In-Network:** You pay a $125 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $200 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $250 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Therapeutic radiology services (such as radiation treatment for cancer):** | **In-Network:** You pay 20% coinsurance per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay 20% coinsurance per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay 20% coinsurance per service<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Hearing Services** | Medicare-covered hearing services are exams to diagnose and treat diseases, balance issues, and other medical conditions of the ear. | | |
| **Medicare-covered hearing exam** | **In-Network:** You pay a $25 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $30 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per service<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Hearing Services (Supplemental)** | Members are required to use the plan's audiology network of providers for In-Network routine hearing exams and hearing aid benefit coverage. You will pay more when utilizing Out-of-Network providers.<br><br>Routine hearing exam copays and hearing aid allowance does not apply to your maximum out-of-pocket limit (MOOP) or deductible. | | |
| **Routine hearing exam** | **In-Network:** You pay $0 copay for 1 routine hearing exam every year<br><br>**Out-of-Network:** You pay 50% coinsurance of the total billed cost for 1 routine hearing exam every year | | |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Hearing Services (Supplemental)** | Members are required to use the plan's audiology network of providers for In-Network routine hearing exams and hearing aid benefit coverage. You will pay more when utilizing Out-of-Network providers.<br><br>Routine hearing exam copays and hearing aid allowance does not apply to your maximum out-of-pocket limit (MOOP) or deductible. | | |
| **Hearing aids (both ears combined)** | **In-Network:**<br>You pay $0 copay for 1 hearing aid fitting/evaluation every three years<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of the total billed cost for 1 hearing aid fitting/evaluation every three years<br><br>**In- and Out-of-Network:**<br>$800 combined plan maximum allowance for hearing aid(s) every three years | | |
| **Hearing Aids provided by Nations Hearing may have lower costs and additional hearing aid program features as follows:** | | | |
| • 3 follow up visits within one year of your fitting<br>• Access to a nationwide network of 4,000+ trusted providers<br>• Brand-name hearing aids available from major manufacturers<br>• Concierge services by dedicated Member Services | • Three-year manufacturer's repair warranty<br>• Up to 60 batteries per year<br>• One-time replacement coverage for lost, stolen, or damaged hearing aids<br>• 12- and 18-month financing options available through contracted vendor<br>• Available with 0% APR, no money down | | |
| **Dental Services** | Medicare-covered dental services are limited to surgery of the jaw, extraction of teeth to prepare the jaw for radiation treatments (for cancer) or medical services that would be covered when provided by a physician. **Prior authorization required for Medicare-covered dental services.** | | |
| **Medicare-covered dental services** | **In-Network:**<br>You pay a $25 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $30 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $40 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Preventive Dental Services** | Members are required to use the plan's dental network providers to receive In-Network preventive dental services. You will pay more when utilizing Out-of-Network providers.<br><br>Preventive dental exam, cleaning, and set of bite-wing x-rays do not apply to the maximum out-of-pocket limit (MOOP), deductible, or to the comprehensive dental plan annual maximum. | | |
| **Routine dental exam** | **In-Network:**<br>You pay a $10 copay per routine dental exam<br>Routine dental exam includes oral exam, cleaning, and one set of bitewing x-rays<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of the total billed cost for a dental exam<br><br>**In- and Out-of-Network:**<br>Limit of two per year - routine dental exam/cleaning and set of bitewing x-rays<br>Fluoride treatments are <u>not</u> covered | | |
| **Comprehensive Dental Services** | Members are required to use the plan's dental network providers to receive In-Network comprehensive dental services. You will pay more when utilizing Out-of-Network providers.<br><br>Comprehensive dental services have a $2,000 combined maximum plan allowance per year, the member is responsible for all dental costs once this annual maximum is met. Comprehensive dental services do not apply to the maximum out-of-pocket limit (MOOP) or deductible.<br><br>**Pre-Treatment comprehensive dental estimates are recommended before service(s) are performed.** | | |
| **Comprehensive dental services** | **In-Network:**<br>You pay 50% coinsurance of the plan allowed amount until the plan maximum is met<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of the total billed cost until the plan maximum is met<br><br>**In- and Out-of-Network**<br>$2,000 combined maximum plan allowance per calendar year<br><br>The following comprehensive dental services are included:<br>• Teeth fillings – amalgam and composite (only)<br>• Simple extractions (non-surgical)<br>• Major restorative services- includes crowns, inlays, onlays | | |

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Comprehensive dental services *(continued)*** | • Endodontics - includes dentures, partials, bridges<br>• Prosthodontics<br>• Palliative care – limited to emergency treatment and periapical x-rays<br>• Adjustments and repairs of prosthetics | | |
| **Vision Services** | Medicare-covered vision services are exams to diagnose and treat diseases and medical conditions of the eye. | | |
| **Medicare-covered vision exam** | **In-Network:**<br>You pay a $25 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $30 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $40 copay per service<br><br>**Out-of-Network:**<br>Same as In-Network[1] |
| **Annual glaucoma screening or diabetic retinal eye exam** | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] | **In-Network:**<br>You pay a $0 copay<br><br>**Out-of-Network:**<br>20% coinsurance[1] |
| **Vision Services (Supplemental)** | Members are required to use the plan's vision network providers to receive In-Network routine vision exams and eyewear. You will pay more when utilizing Out-of-Network providers. Out-of-Network eyeglass lenses will only be reimbursed up to plan's network allowed amount.<br><br>Member is responsible for all eyewear costs once the plan maximum is met every two years. The plan will pay for either frames/lenses or contact lenses within a benefit period, but not both.<br><br>Routine vision exam copays and eyewear (frames and lenses) do not apply to your maximum out-of-pocket limit (MOOP) or deductible. | | |
| **Routine eye exam** | **In-Network:**<br>You pay a $20 copay<br>for 1 routine eye exam every year<br><br>**Out-of-Network:**<br>Plan will reimburse the member 50% of the providers billed amount<br>for 1 routine eye exam every year | | |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Standard lenses**<br><br>**Eyeglass frames or contact lenses** | **In-Network:**<br>You pay $0 copay for single, bifocal, or trifocal eyeglass lenses from a network vision provider up to their allowed amount every two years<br><br>**Out-of-Network:**<br>Plan will reimburse the member up to our In-Network provider allowed amount for eyeglass lenses (single, bifocal, trifocal) every two years<br><br>**In- and Out-of-Network:**<br>$125 combined maximum plan allowance for eyeglass frames (or contacts in lieu of eyewear) every two years. | | |
| **Mental Health Services** | **Prior authorization is required for inpatient mental health services and outpatient mental health/substance abuse services.**<br><br>Inpatient mental health care services received in a psychiatric hospital have a lifetime limit of 190 days. This 190-day limit does not apply to inpatient mental health care provided in a psychiatric unit of an acute care hospital.<br><br>Telehealth visits are covered at the office visit copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits. | | |
| **Inpatient mental health services** | **In-Network**<br>You pay:<br>$100 copay per day for days 1 through 6 per stay<br><br>Copays per day apply per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] | **In-Network**<br>You pay:<br>$225 copay per day for days 1 through 7 per stay<br><br>Copays per day apply per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] | **In-Network**<br>You pay:<br>$335 copay per stay<br><br>Copay applies per admission<br><br>**Out-of-Network**<br>Same copay as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Mental Health Services** *(continued)* | **Prior authorization is required for inpatient mental health services and outpatient mental health/substance abuse services.** Telehealth visits are covered at the office visit copay listed below, if your network provider is able to offer telehealth as an alternative to face to face visits. | | |
| **Outpatient mental health therapy visit** | **In-Network:** You pay a $30 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] | **In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] | **In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] |
| **Outpatient substance abuse visit** | **In-Network:** You pay a $30 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] | **In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] | **In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** Same copay as In-Network[1] |
| **Skilled Nursing Facility (SNF)** | **Prior authorization required.** The plan covers 100 days per benefit period. | | |
| **Skilled nursing stay** | **In-Network:** You pay: $0 copay per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-Network:** Same copay as In-Network[1] Copays indicated above are for each skilled nursing facility admission. | **In-Network:** You pay: $0 copay per day for days 1 through 20 $178 copay per day for days 21 through 100 **Out-of-Network:** Same copay as In-Network[1] Copays indicated above are for each skilled nursing facility admission. | **In-Network:** You pay: $0 copay per day for days 1 through 20 $178 copay per day for days 21 through 100 **Out-of-Network:** Same copay as In-Network[1] Copays indicated above are for each skilled nursing facility admission. |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Skilled Nursing Facility (SNF) *(continued)*** | **Prior authorization required.**<br>The plan covers 100 days per benefit period. | | |
| **SNF benefit period** | Our plan follows the Original Medicare benefit period for SNF stays. A benefit period begins the day you enter an inpatient or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient or skilled care for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. | | |
| **Physical Therapy** | **Prior authorization may be required.** | | |
| **Physical therapy, speech and language therapy, or occupational therapy** | **In-Network:**<br>You pay a $25 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $35 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $40 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] |
| **Ambulance** | **Prior authorization required for non-emergency ambulance services.**<br><br>Ambulance copay is not waived if admitted. | | |
| **Ground ambulance** | **In-Network:**<br>You pay a $150 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $200 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $300 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] |
| **Air ambulance** | **In-Network:**<br>You pay a $150 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $200 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $300 copay per one-way trip<br><br>**Out-of-Network:**<br>Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Transportation (non-emergent)** | **In-Network:**<br>You pay $0 copay for **up to 24 round trips** transportation services (non- emergent) to plan-approved medical locations every year.<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of total charges<br><br>**Plan approved locations include:**<br>• Doctors' offices<br>• Outpatient facilities / centers<br>• Clinics<br>• Other health care related locations<br><br>**You must receive prior approval from the plan for transportation services. Members must use plan's contracted vendor to receive network transportation services.** Contact Member Services or refer to the Evidence of Coverage for more details.<br><br>Transportation services do not apply to the maximum out-of-pocket or deductible. | | Transportation services are **not** covered on BlueJourney Select PPO |
| **Medicare Part B Drugs** | **Prior authorization is required for Part B drugs.** Step Therapy may be required for certain Part B drugs. | | |
| **Chemotherapy drugs** | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] |
| **Other Part B drugs** | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay 20% coinsurance<br><br>**Out-of-Network:**<br>Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

# Prescription Drug Benefits

Generally, our plan has a broad pharmacy network. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.

## 1. Deductible Stage

These plans do not have deductibles for Part D drug benefits. Because there is no deductible for the plan, this payment stage does not apply to you.

## 2. Initial Coverage Stage

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail and Mail Order Pharmacy

You begin in this stage when you fill your first prescription of the year.

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part **D** plan payments) total **$4,130.**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $4,130. When you reach an out-of-pocket limit of $4,130, you leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

- You may get your drugs at network retail pharmacies and mail order pharmacies.
- If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.
- You may get drugs from an Out-of-Network pharmacy, but may pay more than you pay at an In-Network pharmacy.

## 2. Initial Coverage Stage *(Continued)*

| BlueJourney Prime (PPO) | Preferred Retail and Mail Order Pharmacy 30/90 Day Supply | Standard Retail and Mail Order Pharmacy 30/90 Day Supply | Long Term Care Pharmacy 31 Day Supply |
|---|---|---|---|
| **Tier 1: Preferred Generic Drugs** | **$0 / $0 copay** | **$8 / $24 copay** | **$8 copay** |
| **Tier 2: Generic Drugs** | **$5 / $15 copay** | **$20 / $60 copay** | **$20 copay** |
| **Tier 3: Preferred Brand Drugs** | **$40 / $120 copay** | **$47 / $141 copay** | **$47 copay** |
| **Tier 4: Non-Preferred Drugs** | **$93 / $279 copay** | **$100 / $300 copay** | **$100 copay** |
| **Tier 5: Specialty Drugs** | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 30-day supply |
| **Tier 6: Select Care Drugs** | **$0 / $0 copay** | **$7 / $21 copay** | **$7 copay** |
| **Select Insulins*** | **$5 copay** for a 30-day supply | **$5 copay** for a 30-day supply | **$5 copay** for a 30-day supply |

| BlueJourney Classic (PPO) | Preferred Retail and Mail Order Pharmacy 30/90 Day Supply | Standard Retail and Mail Order Pharmacy 30/90 Day Supply | Long Term Care Pharmacy 31 Day Supply |
|---|---|---|---|
| **Tier 1: Preferred Generic Drugs** | **$0 / $0 copay** | **$10 / $30 copay** | **$10 copay** |
| **Tier 2: Generic Drugs** | **$5 / $15 copay** | **$20 / $60 copay** | **$20 copay** |
| **Tier 3: Preferred Brand Drugs** | **$40 / $120 copay** | **$47 / $141 copay** | **$47 copay** |
| **Tier 4: Non-Preferred Drugs** | **$93 / $279 copay** | **$100 / $300 copay** | **$100 copay** |
| **Tier 5: Specialty Drugs** | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 31-day supply |
| **Tier 6: Select Care Drugs** | **$0 / $0 copay** | **$7 / $21 copay** | **$7 copay** |
| **Select Insulins*** | **$5 copay** for a 30-day supply | **$5 copay** for a 30-day supply | **$5 copay** for a 30-day supply |

* All insulins listed on our Drug List (Formulary) are Select Insulins. The most recent Drug List is on our website at CapitalBlueMedicare.com or contact the plan.

## 2. Initial Coverage Stage *(Continued)*

| BlueJourney Select (PPO) | Preferred Retail and Mail Order Pharmacy 30/90 Day Supply | Standard Retail and Mail Order Pharmacy 30/90 Day Supply | Long Term Care Pharmacy 31 Day Supply |
|---|---|---|---|
| **Tier 1: Preferred Generic Drugs** | **$8 / $24 copay** | **$15 / $45 copay** | **$15 copay** |
| **Tier 2: Generic Drugs** | **$12 / $36 copay** | **$20 / $60 copay** | **$20 copay** |
| **Tier 3: Preferred Brand Drugs** | **$40 / $120 copay** | **$47 / $141 copay** | **$47 copay** |
| **Tier 4: Non-Preferred Drugs** | **$93 / $279 copay** | **$100 / $300 copay** | **$100 copay** |
| **Tier 5: Specialty Drugs** | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 30-day supply | **33%** Coinsurance Specialty drugs limited to a 30-day supply |
| **Tier 6: Select Care Drugs** | **$0 / $0 copay** | **$7 / $21 copay** | **$7 copay** |

**NOTE: BlueJourney Select PPO does NOT offered the Select Insulin program.**

## 3. Coverage Gap Stage (Donut Hole)

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail and Mail Order Pharmacy.

The coverage gap begins after the total yearly costs of your drugs (including what our plan has paid and what you have paid) reaches **$4,130**.

**BlueJourney Prime PPO and BlueJourney Classic PPO:** offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be a $5 copay for 30 day supply. All insulins listed on our Drug List are Select Insulins. You can review the most recent Drug List on our website at CapitalBlueMedicare.com. If you have questions about the Drug List, you can also call Member Services.

**BlueJourney Select PPO does not offer the select insulin program.**

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2021, that amount is $6,550. When you reach an out-of-pocket limit of $6,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

## 4. Catastrophic Coverage Stage

What you pay for: **Preferred** Retail/Mail Order Pharmacy OR **Standard** Retail/Mail Order Pharmacy

When you (or those paying on your behalf) have spent a total of **$6,550** in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$6,550** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:
    - o – either – coinsurance of 5% of the cost of the drug
    - o – or – $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs.

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Virtual Care Visits** | **Convenient Care – Everywhere**<br>From your **phone, tablet, or computer,** make an appointment to meet with a Capital BlueCross Virtual Care doctor or behavioral health specialist within minutes. After your visit, be sure to share your visit summary with your Primary Care Physician (PCP). Services are provided by the plan's contracted vendor*. Refer to the Evidence of Coverage for more detail or contact the plan.<br>**In-Network:**<br>You pay $0 copay for virtual care visits received through our plan.<br>**Out-of-Network:**<br>Please refer to the Evidence of Coverage or contact the plan<br><br>Virtual care visits received through the plan's vendor do not apply to the maximum out-of-pocket limit or deductible. | | |

| Overview | Medical | Counseling | Psychiatry | Nutrition Counseling |
|---|---|---|---|---|
| **Doctors and counselors** | Capital BlueCross Virtual Care providers are licensed doctors that have an average of 15 years of experience. | Capital BlueCross Virtual Care counseling services are provided by licensed psychologists and master's level counselors. | Capital BlueCross Virtual Care psychiatry services are provided by board- certified psychiatrists and neurologists. | Capital BlueCross Virtual Care nutrition counseling services are provided by dieticians who provide nutrition advice and diet plans based on personal health needs. |
| **Treatment for conditions such as, but not limited too** | • Abdominal pain<br>• Respiratory infections<br>• Sore Throat<br>• Flu<br>• Pink eye<br>• and more | • Anxiety<br>• Grief<br>• Depression<br>• LGBTQ counseling<br>• Trauma | • Anxiety<br>• Bipolar disorder<br>• Post-traumatic stress<br>• Obsessive compulsive disorder | • Diabetes<br>• Digestive disorders<br>• Food allergies<br>• High cholesterol<br>• Meal planning<br>• Weight loss |
| **Availability** | 24/7 (including weekends and holidays) No appointment necessary. | 7 a.m. – 11 p.m. EST, 7 days a week, by appointment (same day appointment may be possible). | Patients can typically get appointments within 14 days, and a psychiatrist will schedule follow-up visits as needed. | Appointments are available 7 days a week, including evenings. Follow-up appointments are available as necessary. |

*On behalf of Capital BlueCross, American Well Corp. provides this online virtual healthcare tool. American Well is an independent company.

<table>
<tr><th>Additional Health Benefits</th><th>BlueJourney Prime (PPO)</th><th>BlueJourney Classic (PPO)</th><th>BlueJourney Select (PPO)</th></tr>
<tr><td>In Home Support Services</td><td colspan="2">In Home Support services are provided by the plan's contracted vendor, Papa Pals**. Services must be arranged by the plan. Contact the plan or refer to the Evidence of Coverage for more details.<br><br>In home support services do not apply to the maximum out-of-pocket limit or deductible.</td><td rowspan="2">In Home Support Services are <u>not</u> covered on BlueJourney Select PPO</td></tr>
<tr><td>In Home Support Services (Grand Kids On-Demand)</td><td colspan="2">In-Network:<br>You pay $0 copay for up to 5 one-hour visits per month<br><br>Out-of-Network:<br>You pay 50% coinsurance applied to billed charges up to 5 one hour visits per month<br><br>Additional hours above the monthly plan maximum may be purchased by the member from Papa Pals.<br><br><u>Program Overview:</u><br>Papa Pals connects college students to older adults to provide the following services:<br><br>House Help: Helps you or your loved ones around the house. Papa Pals can help with light cleaning, laundry, cooking, and taking care of your pets.<br><br>Companionship Services: Provides amazing companionship to members. Papa Pals can take members out, hang around, watch a movie, play board games or just have a conversation.<br><br>Grocery Shopping: Assist with grocery shopping. Papa Pals will pick members up at their homes, take members to the supermarket, carry your shopping bags, and take you back home.<br><br>Technology Lessons: Teach members how to use technology. Papa Pals will teach members how to use a computer, smartphone, and tablet; how to use social media and how to video chat with your grandkids and other loved ones.<br><br>Social Transportation: Provides older adults with transportation and companionship all the way to and from the member's destinations. Members can receive rides to the doctor's office, to the airport, to their community centers, jobs, and other locations.</td></tr>
</table>

**Papa Pals is a program of Papa Inc. On behalf of Capital BlueCross, Papa Inc. assists in the administration of the Papa Pals program. Papa Inc. is an independent company.

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Special Supplemental Benefit for the Chronically Ill** | Our plan understands the importance of nutrition and healthy fresh food when managing certain chronic medical conditions.<br><br>BlueJourney Prime PPO and BlueJourney Classic PPO members are eligible to receive a Fresh Produce Box from our plan each month if they have <u>one</u> of the following qualified medical conditions:<br><br>**<u>Eligibility Criteria:</u>**<br><br>• Diabetes<br>• Chronic lung disorder<br>• Congestive heart failure<br>• Cardiovascular disease<br><br>The Fresh Produce Box does not apply to the maximum out-of-pocket limit or deductible. | | Special Supplemental Benefit for the Chronically Ill (Fresh Produce Box) is **<u>not</u>** covered on BlueJourney Select PPO |
| **Fresh Produce Box** | **In- and Out-of-Network:**<br><br>Qualified members pay $0 copay for one Fresh Produce Box per month.<br><br>The Fresh Produce Box is available to members that have one of the qualifying medical conditions listed above and have called the plan to opt into the program.<br><br>**<u>Program Overview:</u>**<br><br>The Fresh Produce Box is provided by the plan's contracted vendor. Members that have <u>one</u> of the following medical conditions: diabetes, chronic lung disorder, congestive heart failure, or cardiovascular disease are eligible to receive the fresh product box. **Eligible members must call our plan to opt in (enroll) for the monthly produce box.** Once you enroll you will receive the box monthly unless you would call the plan to end or skip the monthly shipment.<br><br>**Members must meet the eligibility criteria to receive this benefit.** | | |

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Meals - Post Hospital Discharge** | Post hospital discharge meals are provided by the plan's contracted vendor. Services must be arranged by the plan. Contact the plan or see Evidence of Coverage for details on how to obtain this service.<br><br>BlueJourney Healthy Healing Meals do not apply to the maximum out-of-pocket limit or deductible. | | Meals are **not** covered on BlueJourney Select PPO |
| **BlueJourney Healthy Healing Meals program** | **In-Network:**<br>You pay $0 copay for BlueJourney Healthy Healing Meals following an inpatient hospital discharge. You may receive 14 meals over seven days (2 meals per day) after each inpatient hospital stay.<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of the total cost for 14 meals (2 per day) over 7 days after an inpatient hospital stay.<br><br>**Program overview:**<br>Eligible members who have been discharged from a hospital receive fully-prepared, nutritionally-balanced meals to support healing during recuperation.<br><br>Our Healthy Healing Meals program provides a customized plan for members and is designed to enhance recovery and healing after hospital discharge.<br><br>The meals are developed by registered dietitians to ensure all meals are low in sodium, fat, sugar, and cholesterol. All meals are easy to prepare and shelf stable. | | |
| **Chiropractic Care** | **Prior authorization may be required.**<br>Our plan covers Medicare-covered manual manipulation of the spine to correct subluxation. | | |
| **Chiropractic visits (manual manipulation)** | **In-Network:**<br>You pay a $20 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $20 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>You pay a $20 copay per visit<br><br>**Out-of-Network:**<br>Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Diabetes Supplies and Training** | **Prior authorization may be required.** | | |
| **Diabetes self-management training** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Diabetic supplies** | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br><br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Therapeutic shoes and inserts** | **In-Network:** You pay 20% coinsurance<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br><br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Podiatry services** | Our plan covers Medicare-covered podiatry services that diagnose and treat medical conditions of the feet. | | |
| **Foot exams and treatment** | **In-Network:** You pay a $25 copay per visit<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $35 copay per visit<br><br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per visit<br><br>**Out-of-Network:** Same as In-Network[1] |
| **Home Health Care** | **Prior authorization required.** | | |
| **Home health visits** | **In-Network:** You pay a $0 copay per visit<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay per visit<br><br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay per visit<br><br>**Out-of-Network:** You pay 20% coinsurance[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Other Therapy Services** | **Prior authorization may be required.** Copays are per session. | | |
| **Cardiac (heart) rehab services** (Maximum of 2 one-hour sessions per day for up to 36 sessions) | **In-Network:** You pay a $25 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $35 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per visit<br>**Out-of-Network:** Same as In-Network[1] |
| **Intensive cardiac rehabilitation** (Maximum of 72 one-hour sessions, 6 per day up to 18 weeks) | **In-Network:** You pay a $25 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $35 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per visit<br>**Out-of-Network:** Same as In-Network[1] |
| **Pulmonary rehabilitation services** | **In-Network:** You pay a $25 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $30 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $30 copay per visit<br>**Out-of-Network:** Same as In-Network[1] |
| **Supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD)** | **In-Network:** You pay a $10 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $10 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $10 copay per visit<br>**Out-of-Network:** Same as In-Network[1] |
| **Opioid treatment service** | **In-Network:** You pay a $30 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per visit<br>**Out-of-Network:** Same as In-Network[1] | **In-Network:** You pay a $40 copay per visit<br>**Out-of-Network:** Same as In-Network[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Medical Equipment/ Supplies** | **Prior authorization may be required for select DME or prosthetic devices** | | |
| **Durable medical equipment (DME) and supplies** (such as oxygen, wheelchairs) | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Prosthetics** (such as braces, artificial limbs, ostomy supplies) | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Renal Dialysis (ESRD)** | **Prior authorization may be required for select ESRD services.** | | |
| **Kidney dialysis** | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay 20% coinsurance<br>**Out-of-Network:** You pay 20% coinsurance[1] |
| **Kidney disease education services** | **In-Network:** You pay a $0 copay per visit<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay per visit<br>**Out-of-Network:** You pay 20% coinsurance[1] | **In-Network:** You pay a $0 copay per visit<br>**Out-of-Network:** You pay 20% coinsurance[1] |

[1] Copay/coinsurance applies after the deductible has been met

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Acupuncture** | Our plan provides Medicare-covered acupuncture for chronic low back pain (only). Coverage includes up to 12 visits, plus 8 additional visits are covered if your condition is improving. | | |
| **Acupuncture visits** | **In-Network:**<br>$5 copay - PCP performs<br>$20 copay - chiro performs<br>$25 copay - specialist performs<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>$5 copay - PCP performs<br>$20 copay - chiro performs<br>$30 copay - specialist performs<br><br>**Out-of-Network:**<br>Same as In-Network[1] | **In-Network:**<br>$5 copay - PCP performs<br>$20 copay - chiro performs<br>$40 copay - specialist performs<br><br>**Out-of-Network:**<br>Same as In-Network[1] |
| **Over the Counter (OTC) Items** | Our plan gives you a fixed-dollar amount each month to purchase over-the-counter (OTC) medications and supplies you need to stay well. Includes OTC items such as, bandages, pain relievers, cold remedies, toothpaste and more. Please visit our website to see our current list of covered OTC items or contact the plan.<br>You must use the plan's vendor to purchase OTC items, contact the plan or refer to the Evidence of Coverage for additional information.<br><br>OTC items do not apply to the maximum out-of-pocket limit or deductible. | | |
| **OTC Allowance** | **In- and Out-of-Network:**<br>$25 monthly allowance for Over-the Counter (OTC) drugs and supplies<br><br>Unused OTC allowance may not be carried over from one month to the next month. | | |

[1] Copay/coinsurance applies after the deductible has been met

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Wellness Programs** | Contact the plan or see Evidence of Coverage for more details on Wellness programs. | | |
| **SilverSneakers® gym membership** | **17,000+ Locations Across the U.S. \| 70+ Fitness Classes \| 1 Amazing Membership**<br><br>SilverSneakers®* is a health and fitness program designed for adults 65+ years of age. This fitness benefit includes fitness facility membership or home-based programs, as well as web services and quarterly newsletters. The fitness facility membership includes orientation to the facility and equipment. You must use a SilverSneakers fitness facility. To obtain a list of In-Network fitness centers, please see our website at www.CapitalBlueMedicare.com.<br><br>**On-demand workouts:**<br>Use your SilverSneakers membership to login to our on-demand video library of classes, workouts, and how-to videos. **Getting active just got easier with SilverSneakers® GO, the first fitness app designed just for you.**<br><br>SilverSneakers fitness membership does not apply to the maximum out-of-pocket limit or deductible. | | |
| | **In-Network:**<br>You pay $0 copay for the SilverSneakers fitness program<br><br>As a BlueJourney member, you get all of the location access, SilverSneakers classes, on-demand videos, and perks of membership at no additional cost.<br><br>**Out-of-Network:**<br>SilverSneakers offers a nationwide network of fitness facilities please refer to the Evidence of Coverage or contact the plan. | | |

*SilverSneakers is a program of Tivity Health. On behalf of Capital BlueCross, Tivity Health assists in the administration of this fitness program. Tivity Health is an independent company.

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **Wellness Programs** | Contact the plan or see Evidence of Coverage for more details. | | |
| **Health Education** | Health Coaches provide personalized expert advice and coaching to support members. Our Health Coaches have backgrounds in a variety of health fields and are trained and certified in health coaching.<br><br>Counseling services can be provided by phone or in person by visiting the Chambersburg, Enola, and Lehigh Valley Capital BlueCross Connect Stores.<br><br>Health Education does not apply to the maximum out-of-pocket limit or deductible. | | |
| | **In-Network:**<br>You pay $0 copay for three 30-minutes sessions per year with our Health Coaches<br><br>**Out-of-Network:**<br>Please refer to the Evidence of Coverage or contact the plan | | |
| **Medical Nutritional Therapy** | **Medical Nutrition Therapy (MNT)** can help you better manage certain conditions through dietary counseling and changes to your eating habits. Our plan provides you with an opportunity to have unlimited visits to see a registered dietician or other qualified nutrition specialist with a physician's order (script) for MNT services.<br><br>Covered conditions include but are not limited to: diabetes, renal disease, or individuals who have received a kidney transplant in the last three years, digestive disorders, food allergies, high cholesterol, and hypertension. Meal-planning and weight loss consultations are also provided as an option.<br><br>MNT services must be provided by a network provider licensed in nutrition or network dietician. Providers can perform MNT services in an office or via telehealth. You can also obtain MNT services from our plan's virtual care vendor. | | |
| | **In-Network:**<br>You pay a $0 copay for medical nutritional therapy visits<br><br>**Out-of-Network:**<br>You pay 50% coinsurance of the total billed charges | | |

| Additional Health Benefits | BlueJourney Prime (PPO) | BlueJourney Classic (PPO) | BlueJourney Select (PPO) |
|---|---|---|---|
| **BlueJourney PPO Network Sharing Visitor Travel Program** | **BlueJourney PPO members are covered In-Network when traveling outside of the Capital BlueCross 21-county service area.**<br><br>**Program Overview:**<br>**In addition to standard in- and Out-of-Network benefits, all BlueJourney PPO members have access to the Blue Cross Blue Shield Association Visitor and Travel Program.** When traveling outside of Capital BlueCross' 21 county provider network,<br><br>BlueJourney PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider in any geographic area where the Visitor and Travel Program is offered. Members will pay the same In-Network cost-share amount they would have paid using an In-Network provider in our service area.<br><br>The Visitor/Travel Program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and supplemental benefits offered by your plan outside your service area. The Visitor Travel Network includes 43 states and 1 territory including: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia.<br>For some of the states listed, MA PPO networks are only available in portions of the state, contact the plan for more information. | | |

This information is not a complete description of benefits. Please call Member Services at 1-866-987-4213 (TTY: 711) for more information.

For help and information:

**BlueJourney PPO**
**1-800-990-4201**

**Current members**
**1-866-987-4213** (TTY: 711)
April 1 through September 30
8 a.m. to 8 p.m., Monday through Friday
October 1 through March 31
8 a.m. to 8 p.m., seven days a week

Capital BLUE

# MEDICARE

CapitalBlueMedicare.com

BlueJourney PPO is offered by Capital Advantage Insurance Company®, a Medicare Advantage organization with a Medicare contract. Enrollment in BlueJourney PPO depends on contract renewal.

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SOB21-01 (09/16/20)