Capital

2023 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Capital Blue Cross Select (PPO)
BlueJourney Classic (PPO)
BlueJourney Prime (PPO)

January 1, 2023 – December 31, 2023

H3923_23SB281317_M

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at CapitalBlueMedicare.com. You may also call us and ask us to mail you an 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 **Capital Blue Cross Select (PPO), BlueJourney Classic (PPO) and BlueJourney Prime (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Capital Blue Cross Select (PPO), BlueJourney Classic (PPO)** and **BlueJourney Prime (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 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 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 **Capital Blue Cross Select (PPO), BlueJourney Classic (PPO)** and **BlueJourney Prime (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).

Hours of operation and contact information

- From October 1 to March 31 we're open 8:00 AM to 8:00 PM ET, 7 days a week.
- From April 1 to September 30, we're open 8:00 AM to 8:00 PM ET, Monday through Friday.
- If you are a member of this plan, call us at 1-866-987-4213, TTY: 711.
- If you are not a member of this plan, call us at 1-800-990-4201, TTY: 711.
- Our website: CapitalBlueMedicare.com.

Who can join?

To join **Capital Blue Cross Select (PPO), BlueJourney Classic (PPO) and BlueJourney Prime (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for **Capital Blue Cross Select (PPO)** 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.
The service area for **BlueJourney Classic (PPO)** 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.
The service area for **BlueJourney Prime (PPO)** 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?

Capital Blue Cross Select (PPO), BlueJourney Classic (PPO) and **BlueJourney Prime (PPO)** have 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.

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/pharmacy directory at our website (CapitalBlueMedicare.com). Or, call us and we will send you a copy of the provider/pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including 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.

How will I determine my drug costs?

Our plan groups each medication into one of five "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.

If you have any questions about this plan's benefits or costs, please contact Capital Blue Cross.

2 SECTION II - SUMMARY OF BENEFITS

	Capital Blue Cross Select (PPO)	BlueJourney Classic (PPO)	BlueJourney Prime (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	You do not pay a separate monthly plan premium for Capital Blue Cross Select (PPO). You must continue to pay your Medicare Part B premium.	$51 per month. In addition, you must keep paying your Medicare Part B premiums.	$174 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.

Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $7,000 for services you receive from in-network providers. • $7,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • $10,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $4,000 for services you receive from in-network providers. • $8,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital	**In-Network:** $325 Copay per stay May require prior authorization. **Out-of-Network:** $325 Copay per stay.	**In-Network:** Days 1-5: $240 Copay per day per stay. May require prior authorization. **Out-of-Network:** Days 1-5: $240 Copay per day per stay.	**In-Network:** Days 1-5: $125 Copay per day per stay. May require prior authorization. **Out-of-Network:** Days 1-5: $125 Copay per day per stay.

Outpatient Hospital (Surgery)	**<u>In-Network:</u>** Outpatient Surgery: $0 - $330 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services. May require prior authorization. **<u>Out-of-Network:</u>** Outpatient Surgery: $0 - $330 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services.	**<u>In-Network:</u>** Outpatient Surgery: $0 - $300 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services. May require prior authorization. **<u>Out-of-Network:</u>** Outpatient Surgery: $0 - $300 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services.	**<u>In-Network:</u>** Outpatient Surgery: $0 - $225 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services. May require prior authorization. **<u>Out-of-Network:</u>** Outpatient Surgery: $0 - $225 Copay. • $0 for Dermatology and Podiatry surgical services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient surgical services.

Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 - $330 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services. May require prior authorization. **Out-of-Network:** Ambulatory Surgical Center: $0 - $330 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services.	**In-Network:** Ambulatory Surgical Center: $0 - $225 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services. May require prior authorization. **Out-of-Network:** Ambulatory Surgical Center: $0 - $225 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services.	**In-Network:** Ambulatory Surgical Center: $0 - $125 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services. May require prior authorization. **Out-of-Network:** Ambulatory Surgical Center: $0 - $125 Copay. • $0 for Dermatology and Podiatry ambulatory surgical center services received in an office setting and outpatient Electroconvulsive therapy services. • Higher cost sharing: for all other outpatient ambulatory surgical center services.

Doctor's Office Visits	**In-Network:** Primary care physician visit: $5 Copay. Specialist visit: $40 Copay. **Out-of-Network:** Primary care physician visit: $5 Copay. Specialist visit: $40 Copay.	**In-Network:** Primary care physician visit: $5 Copay. Specialist visit: $30 Copay. **Out-of-Network:** Primary care physician visit: $5 Copay. Specialist visit: $30 Copay.	**In-Network:** Primary care physician visit: $5 Copay. Specialist visit: $25 Copay. **Out-of-Network:** Primary care physician visit: $5 Copay. Specialist visit: $25 Copay.
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network:** $0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 20% Coinsurance for all preventive services.	**In-Network:** $0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 20% Coinsurance for all preventive services.	**In-Network:** $0 Copay for all preventive services. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 20% Coinsurance for all preventive services.
Emergency Care	**In-Network and Out-of-Network:** $95 Copay per visit.	**In-Network and Out-of-Network:** $95 Copay per visit.	**In-Network and Out-of-Network:** $95 Copay per visit.
Urgently Needed Services	**In-Network and Out-of-Network:** $50 Copay per visit.	**In-Network and Out-of-Network:** $45 Copay per visit.	**In-Network and Out-of-Network:** $35 Copay per visit.

Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 - $25 Copay. • $0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests. • Higher cost sharing for all other non-routine diagnostic tests. Lab services: $0 - $25 Copay. • $0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels. • Higher cost sharing for all other non-routine lab services. Diagnostic Radiology Services (such as MRI, CAT Scan): $200 Copay. X-rays: $25 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $0 - $20 Copay. • $0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests. • Higher cost sharing for all other non-routine diagnostic tests. Lab services: $0 - $20 Copay. • $0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels. • Higher cost sharing for all other non-routine lab services. Diagnostic Radiology Services (such as MRI, CAT Scan): $230 Copay. X-rays: $25 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $0 - $20 Copay. • $0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests. • Higher cost sharing for all other non-routine diagnostic tests. Lab services: $0 - $20 Copay. • $0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels. • Higher cost sharing for all other non-routine lab services. Diagnostic Radiology Services (such as MRI, CAT Scan): $125 Copay. X-rays: $20 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.

	Out-of-Network: Diagnostic tests and procedures: 20% Coinsurance. Lab services: 20% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance. X-rays: 20% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.	**Out-of-Network:** Diagnostic tests and procedures: 20% Coinsurance. Lab services: 20% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance. X-rays: 20% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.	**Out-of-Network:** Diagnostic tests and procedures: $0 - $20 Copay. • $0 for routine/monitoring diagnostic tests such as EKG, EEG, ECG, and stress tests. • Higher cost sharing for all other non-routine diagnostic tests Lab services: $0 - $20 Copay. • $0 for routine/monitoring lab tests, such as A1C test, complete blood counts and lipid panels. • Higher cost sharing for all other non-routine lab services. Diagnostic Radiology Services (such as MRI, CAT Scan): $125 Copay. X-rays: $20 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.

Hearing Services	**<u>In-Network:</u>** Medicare covered Hearing Exam: $40 Copay. Routine hearing exam: $0 Copay. *1 visit every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered Hearing Exam: $40 Copay. Routine hearing exam: 50% Coinsurance. *1 visit every year (combined in and out of network).*	**<u>In-Network:</u>** Medicare covered Hearing Exam: $30 Copay. Routine hearing exam: $0 Copay. *1 visit every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered Hearing Exam: $30 Copay. Routine hearing exam: 50% Coinsurance. *1 visit every year (combined in and out of network).*	**<u>In-Network:</u>** Medicare covered Hearing Exam: $25 Copay. Routine hearing exam: $0 Copay. *1 visit every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered Hearing Exam: $25 Copay. Routine hearing exam: 50% Coinsurance. *1 visit every year (combined in and out of network).*

Dental Services	**<u>In-Network:</u>** Medicare covered dental exam: $40 Copay. Preventive dental services: $10 Copay. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered dental exam: $40 Copay. Preventive dental services: 50% Coinsurance. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).*	**<u>In-Network:</u>** Medicare covered dental exam: $30 Copay. Preventive dental services: $10 Copay. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered dental exam: $30 Copay. Preventive dental services: 50% Coinsurance. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).*	**<u>In-Network:</u>** Medicare covered dental exam: $25 Copay. Preventive dental services: $10 Copay. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).* **<u>Out-of-Network:</u>** Medicare covered dental exam: $25 Copay. Preventive dental services: 50% Coinsurance. • Oral exam. • Cleaning. • Fluoride treatment. • Dental bitewing X-rays. *2 visits every year (combined in and out of network).*

Vision Services	**<u>In-Network:</u>** Medicare covered vision exam: $40 Copay. • $0 Copay applies to glaucoma screening exam or diabetic retinal eye exam. Routine eye exam: $10 Copay. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact lenses after cataract surgery: $0 Copay. Our plan pays up to $150 every year for eyewear or contacts *(combined in and out of network)*. **<u>Out-of-Network:</u>** Medicare covered vision exam: $40 Copay, including diabetic retinal exam. • 20% Coinsurance for glaucoma screening exam Routine eye exam: 50% Coinsurance. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact	**<u>In-Network:</u>** Medicare covered vision exam: $30 Copay. • $0 Copay applies to glaucoma screening exam or diabetic retinal eye exam. Routine eye exam: $20 Copay. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact lenses after cataract surgery: $0 Copay. Our plan pays up to $125 every year for eyewear or contacts *(combined in and out of network)*. **<u>Out-of-Network:</u>** Medicare covered vision exam: $30 Copay, including diabetic retinal exam. • 20% Coinsurance for glaucoma screening exam Routine eye exam: 50% Coinsurance. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact lenses after cataract	**<u>In-Network:</u>** Medicare covered vision exam: $25 Copay. • $0 Copay applies to glaucoma screening exam or diabetic retinal eye exam. Routine eye exam: $20 Copay. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact lenses after cataract surgery: $0 Copay. Our plan pays up to $125 every year for eyewear or contacts *(combined in and out of network)*. **<u>Out-of-Network:</u>** Medicare covered vision exam: $25 Copay, including diabetic retinal exam. • 20% Coinsurance for glaucoma screening exam Routine eye exam: 50% Coinsurance. *1 visit every year (combined in and out of network).* Medicare covered eyeglasses or contact lenses after cataract

	lenses after cataract surgery: 20% Coinsurance. Our plan pays up to $150 every year for eyewear or contacts (*combined in and out of network).*	surgery: 20% Coinsurance. Our plan pays up to $125 every year for eyewear or contacts (*combined in and out of network).*	surgery: 20% Coinsurance. Our plan pays up to $125 every year for eyewear or contacts (*combined in and out of network).*
Mental Health Care	**<u>In-Network:</u>** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: $325 Copay per stay. **<u>Out-of-Network:</u>** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: $325 Copay per stay.	**<u>In-Network:</u>** Outpatient group therapy visit: $30 Copay. Individual therapy visit: $30 Copay. Inpatient Mental Health Care: Days 1-5: $240 Copay per day per stay. **<u>Out-of-Network:</u>** Outpatient group therapy visit: $30 Copay. Individual therapy visit: $30 Copay. Inpatient Mental Health Care: Days 1-5: $240 Copay per day per stay.	**<u>-Network:</u>** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Inpatient Mental Health Care: Days 1-5: $125 Copay per day per stay. **<u>Out-of-Network:</u>** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Inpatient Mental Health Care: Days 1-5: $125 Copay per day per stay.

Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $196 Copay per day. May require prior authorization. **Out-of-Network:** Days 1-20: $0 Copay per day. Days 21-100: $196 Copay per day.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $196 Copay per day. May require prior authorization. **Out-of-Network:** Days 1-20: $0 Copay per day. Days 21-100: $196 Copay per day.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $175 Copay per day. May require prior authorization. **Out-of-Network:** Days 1-20: $0 Copay per day. Days 21-100: $175 Copay per day.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $30 Copay. Physical therapy and speech and language therapy visit: $30 Copay. May require prior authorization. **Out-of-Network:** Occupational therapy visit: $30 Copay. Physical therapy and speech and language therapy visit: $30 Copay.	**In-Network:** Occupational therapy visit: $35 Copay. Physical therapy and speech and language therapy visit: $35 Copay. May require prior authorization. **Out-of-Network:** Occupational therapy visit: $35 Copay. Physical therapy and speech and language therapy visit: $35 Copay.	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay. May require prior authorization. **Out-of-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.

Ambulance	**In-Network:** Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay. May require prior authorization. **Out-of-Network:** Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay.	**In-Network:** Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay. May require prior authorization. **Out-of-Network:** Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay.	**In-Network:** Ground Ambulance: $150 Copay. Air Ambulance: $150 Copay. May require prior authorization. **Out-of-Network:** Ground Ambulance: $150 Copay. Air Ambulance: $150 Copay.
Transportation	**In-Network:** $0 Copay. 16 One-way trips every year to Plan-approved health-related location. Requires prior authorization. Must use our vendor. **Out-of-Network:** $0 Copay. 16 One-way trips every year to Plan-approved health-related location.	**In-Network:** $0 Copay. 48 One-way trips every year to Plan-approved health-related location. Requires prior authorization. Must use our vendor. **Out-of-Network:** $0 Copay. 48 One-way trips every year to Plan-approved health-related location.	**In-Network:** $0 Copay. 48 One-way trips every year to Plan-approved health-related location. Requires prior authorization. Must use our vendor. **Out-of-Network:** $0 Copay. 48 One-way trips every year to Plan-approved health-related location.

Medicare Part B Drugs	**<u>In-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. May require prior authorization. **<u>Out-of-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance.	**<u>In-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. May require prior authorization. **<u>Out-of-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance.	**<u>In-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. May require prior authorization. **<u>Out-of-Network:</u>** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance.
PRESCRIPTION DRUG BENEFITS			
Deductible	Prescription Drug Deductible: Not Applicable.	Prescription Drug Deductible: Not Applicable.	Prescription Drug Deductible: Not Applicable.

<table>
<tr>
<td>Initial Coverage</td>
<td>You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won’t pay more than $15 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

<table>
<tr><th colspan="2">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$12 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$20 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td></tr>
<tr><td>Part D Insulin Saver</td><td>$15 Copay</td></tr>
</table>
</td>
<td>You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won’t pay more than $5 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

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<tr><th>Tier</th><th>One-month supply</th></tr>
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<td>You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

You won’t pay more than $5 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it is on.

<table>
<tr><th colspan="2">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$8 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$20 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td></tr>
<tr><td>Part D Insulin Saver</td><td>$5 Copay</td></tr>
</table>
</td>
</tr>
</table>

Tier	Two-month supply
Tier 1 (Preferred Generic)	$24 Copay
Tier 2 (Generic)	$40 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	$200 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$30 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$36 Copay
Tier 2 (Generic)	$60 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$20 Copay
Tier 2 (Generic)	$40 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	$200 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$10 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$30 Copay
Tier 2 (Generic)	$60 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay
Tier 5 (Specialty Tier)	Not Applicable

Tier	Two-month supply
Tier 1 (Preferred Generic)	$16 Copay
Tier 2 (Generic)	$40 Copay
Tier 3 (Preferred Brand)	$94 Copay
Tier 4 (Non-Preferred Drug)	$200 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$10 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$24 Copay
Tier 2 (Generic)	$60 Copay
Tier 3 (Preferred Brand)	$141 Copay
Tier 4 (Non-Preferred Drug)	$300 Copay
Tier 5 (Specialty Tier)	Not Applicable

Part D Insulin Saver	$45 Copay

Preferred Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$5 Copay
Tier 3 (Preferred Brand)	$40 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay
Tier 5 (Specialty Tier)	33% coinsurance
Part D Insulin Saver	$15 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-	$186 Copay

Part D Insulin Saver	$15 Copay

Preferred Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$5 Copay
Tier 3 (Preferred Brand)	$40 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay
Tier 5 (Specialty Tier)	33% coinsurance
Part D Insulin Saver	$5 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-	$186 Copay

Part D Insulin Saver	$15 Copay

Preferred Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$5 Copay
Tier 3 (Preferred Brand)	$40 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay
Tier 5 (Specialty Tier)	33% coinsurance
Part D Insulin Saver	$5 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-	$186 Copay

	Preferred Drug)		Preferred Drug)		Preferred Drug)	
	Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable
	Part D Insulin Saver	$30 Copay	Part D Insulin Saver	$10 Copay	Part D Insulin Saver	$10 Copay
	Tier	**Three-month supply**	**Tier**	**Three-month supply**	**Tier**	**Three-month supply**
	Tier 1 (Preferred Generic)	$0 Copay	Tier 1 (Preferred Generic)	$0 Copay	Tier 1 (Preferred Generic)	$0 Copay
	Tier 2 (Generic)	$15 Copay	Tier 2 (Generic)	$15 Copay	Tier 2 (Generic)	$15 Copay
	Tier 3 (Preferred Brand)	$120 Copay	Tier 3 (Preferred Brand)	$120 Copay	Tier 3 (Preferred Brand)	$120 Copay
	Tier 4 (Non-Preferred Drug)	$279 Copay	Tier 4 (Non-Preferred Drug)	$279 Copay	Tier 4 (Non-Preferred Drug)	$279 Copay
	Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable	Tier 5 (Specialty Tier)	Not Applicable
	Part D Insulin Saver	$45 Copay	Part D Insulin Saver	$15 Copay	Part D Insulin Saver	$15 Copay
	Mail Order		**Mail Order**		**Mail Order**	
	Tier	**One-month supply**	**Tier**	**One-month supply**	**Tier**	**One-month supply**
	Tier 1 (Preferred Generic)	$0 Copay	Tier 1 (Preferred Generic)	$0 Copay	Tier 1 (Preferred Generic)	$0 Copay
	Tier 2 (Generic)	$5 Copay	Tier 2 (Generic)	$5 Copay	Tier 2 (Generic)	$5 Copay

Tier 3 (Preferred Brand)	$40 Copay	Tier 3 (Preferred Brand)	$40 Copay	Tier 3 (Preferred Brand)	$40 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay	Tier 4 (Non-Preferred Drug)	$93 Copay	Tier 4 (Non-Preferred Drug)	$93 Copay
Tier 5 (Specialty Tier)	33% coinsurance	Tier 5 (Specialty Tier)	33% coinsurance	Tier 5 (Specialty Tier)	33% coinsurance
Part D Insulin Saver	$15 Copay	Part D Insulin Saver	$5 Copay	Part D Insulin Saver	$5 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-Preferred Drug)	$186 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$30 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-Preferred Drug)	$186 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$10 Copay

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$10 Copay
Tier 3 (Preferred Brand)	$80 Copay
Tier 4 (Non-Preferred Drug)	$186 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$10 Copay

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$15 Copay
Tier 3 (Preferred Brand)	$120 Copay
Tier 4 (Non-Preferred Drug)	$279 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$45 Copay

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website CapitalBlueMedicare.com for complete information about your costs for covered drugs.

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$15 Copay
Tier 3 (Preferred Brand)	$120 Copay
Tier 4 (Non-Preferred Drug)	$279 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$15 Copay

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Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$15 Copay
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Tier 4 (Non-Preferred Drug)	$279 Copay
Tier 5 (Specialty Tier)	Not Applicable
Part D Insulin Saver	$15 Copay

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website CapitalBlueMedicare.com for complete information about your costs for covered drugs.

Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. As part of the Part D Insulin Saver Program, you will continue to pay the same copays during the Coverage Gap Stage as you did in the Initial Coverage Stage (listed above) for insulins.
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 Copayment for all other drugs, or • 5% of the cost.	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 Copayment for all other drugs, or • 5% of the cost.	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 Copayment for all other drugs, or • 5% of the cost.

DISCLAIMERS

This document is available in other alternate format.

Capital Blue Cross Select (PPO), **BlueJourney Classic (PPO)** and **BlueJourney Prime (PPO)** are PPO plans with a Medicare contract. Enrollment in **Capital Blue Cross Select (PPO)**, **BlueJourney Classic (PPO)** and **BlueJourney Prime (PPO)** depends on contract renewal. Capital Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Capital Blue Cross members, except in emergency situations. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Capital Advantage Insurance Company.

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 customer service representative at 1-866-987-4213 (TTY 711).

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 (TTY 711) 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.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

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 each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ 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 situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Out-of-network/non-contracted providers are under no obligation to treat **Capital Blue Cross Select (PPO)**, **BlueJourney Classic (PPO)** and **BlueJourney Prime (PPO)** members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

THANK YOU

Connect with us

Contact Information: 1-866-987-4213, TTY: 711

Organization Name: Capital Blue Cross

Organization Website: CapitalBlueMedicare.com