Capital Blue Cross | WellSpan Health PPO

2022 Summary of Benefits

Capital Blue Cross | WellSpan Health AdvantagePlus
Capital Blue Cross | WellSpan Health Advantage

Capital Blue Cross
Medicare

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Your health. Our mission.

Summary of Benefits

January 1, 2022 — December 31, 2022

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 **Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (PPO).**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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 **Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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 Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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.

Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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 **Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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 six counties in Pennsylvania: Adams, Cumberland, Franklin, Lancaster, Lebanon, and York counties; however you may use network providers across our 21-county Medicare Advantage service area to obtain medical care.

Which doctors, hospitals, and pharmacies can I use?

Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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 Capital Blue Cross | WellSpan Health Advantage and AdvantagePlus (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.**

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?

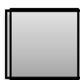
Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the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

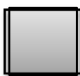
Pre-Enrollment Checklist

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.

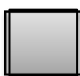
Understanding the Benefits



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.

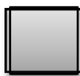


Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor or pay the out-of-network cost-sharing.

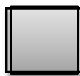


Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

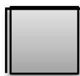
Understanding Important Rules



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, 2023.



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	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Monthly Plan Premium	You pay $0 per month.	You pay $19 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	**In-Network:** This plan has no deductible **Out-of-Network:** This plan has no deductible	**In-Network:** This plan has no deductible **Out-of-Network:** This plan has no deductible
Maximum Out-of-Pocket (MOOP) Responsibility	**In-Network** $6,600 annually **Combined In/Out-of-Network** $11,300 annually	**In-Network** $5,900 annually **Combined In/Out-of-Network** $11,300 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 medical 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 amount. 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. 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.	

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Member Cost	The following 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 Capital Blue Cross | WellSpan Health Advantage. 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. • 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. • **"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.	
Inpatient Hospital Coverage	**Prior authorization required.**	
Inpatient hospital	**In-Network** You pay $300 copay per stay Our plan covers an unlimited number of medically necessary days per hospital stay Copays per stay indicated above apply per admission **Out-of-Network** You pay $300 copay per stay	**In-Network** You pay $275 copay per stay Our plan covers an unlimited number of medically necessary days per hospital stay Copays per stay indicated above apply per admission **Out-of-Network** You pay $275 copay per stay
Outpatient Hospital Coverage	**Prior authorization may be required.** You pay applicable copay per ambulatory surgical center or outpatient hospital visits.	
Ambulatory surgical center	**In-Network:** You pay a $300 copay **Out-of-Network:** You pay a $300 copay	**In-Network:** You pay a $225 copay **Out-of-Network:** You pay a $225 copay

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Outpatient surgery	**In-Network:** You pay a $315 copay **Out-of-Network:** You pay a $315 copay	**In-Network:** You pay a $275 copay **Out-of-Network:** You pay a $275 copay
Outpatient observation stays	**In-Network:** You pay a $300 copay per stay **Out-of-Network:** You pay a $300 copay per stay	**In-Network:** You pay a $275 copay per stay **Out-of-Network:** You pay a $275 copay per stay
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)	**In-Network:** You pay a $0 copay per PCP visit **Out-of-Network:** You pay a $5 copay per PCP visit	**In-Network:** You pay a $0 copay per PCP visit **Out-of-Network:** You pay a $5 copay per PCP visit
Specialists	**In-Network:** You pay a $40 copay per specialist visit **Out-of-Network:** You pay a $40 copay per specialist visit	**In-Network:** You pay a $30 copay per specialist visit **Out-of-Network:** You pay a $30 copay per specialist visit
Annual routine physical exam	**In-Network:** You pay a $0 copay 1 visit per year **Out-of-Network:** 20% coinsurance 1 visit per year	**In-Network:** You pay a $0 copay 1 visit per year **Out-of-Network:** 20% coinsurance 1 visit per year

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Preventive Services	Any additional preventive services approved by Medicare during the contract year will be covered. Additional cost share may apply when other services are performed.	
Preventive services	**In-Network:** You pay a $0 copay for preventive services **Out-of-Network:** 20% coinsurance Services include: flu shots, COVID-19 vaccine, pneumonia vaccine, mammograms, prostate cancer screening, pap and pelvic exam, colorectal screening exams, diabetic screenings, annual wellness exams. Please refer to the Evidence of Coverage for the complete list of preventive services.	
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.)
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.) $20,000 annual plan maximum coverage	**In/Out-of-Network:** You pay a $90 copay per visit (Worldwide – outside the U.S.) $20,000 annual plan maximum coverage
Urgently Needed Services	Your copay is not waived if admitted to the hospital.	
Urgent care	**In/Out-of-Network:** You pay a $50 copay per visit (within the U.S.)	**In/Out-of-Network:** You pay a $50 copay per visit (within the U.S.)

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Worldwide Urgent Care	Coverage of urgent care services when outside the United States and its territories. Copay is not waived if admitted to the hospital. Annual worldwide plan maximum is combined for emergency and urgent care.	
	In/Out-of-Network: You pay a $50 copay per visit (Worldwide – outside the U.S.) $20,000 annual plan maximum coverage	**In/Out-of-Network:** You pay a $50 copay per visit (Worldwide – outside the U.S.) $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. Please refer to the Evidence of Coverage for additional information for the lab services and diagnostic tests copay amounts.	
Lab services	**In-Network:** You pay a $0 or $25 copay per visit **Out-of-Network:** 20% coinsurance	**In-Network:** You pay a $0 or $25 copay per visit **Out-of-Network:** 20% coinsurance
Diagnostic tests and procedures	**In-Network:** You pay a $0 or $25 copay per visit **Out-of-Network:** 20% coinsurance	**In-Network:** You pay a $0 or $25 copay per visit **Out-of-Network:** 20% coinsurance
Outpatient x-rays	**In-Network:** You pay a $25 copay per visit **Out-of-Network:** 20% coinsurance	**In-Network:** You pay a $50 copay per visit **Out-of-Network:** 20% coinsurance

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Diagnostic radiology services *(continued)*	**Prior authorization may be required.** Copay may vary depending on place of service.	
Diagnostic radiology (CT, MRI)	**In-Network:** You pay a $250 copay per visit **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay a $205 copay per visit **Out-of-Network:** You pay 20% coinsurance
Therapeutic radiology services (such as radiation treatment for cancer):	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
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 $40 copay per exam **Out-of-Network:** You pay a $40 copay per exam	**In-Network:** You pay a $30 copay per exam **Out-of-Network:** You pay a $30 copay per exam
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. Routine hearing exam copays and hearing aid allowance does not apply to your maximum out-of-pocket limit (MOOP).	
Routine hearing exam	**In-Network:** You pay $0 copay for 1 routine hearing exam every year **Out-of-Network:** You pay 50% coinsurance of the total billed cost for 1 routine hearing exam every year	

<table>
<tr><th>Health Benefits</th><th>Capital Blue Cross | WellSpan Health Advantage (PPO)</th><th>Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)</th></tr>
<tr><td>Hearing Services (Supplemental) continued</td><td colspan="2">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.</td></tr>
<tr><td>Hearing aids fitting/evaluation</td><td colspan="2">In-Network:
You pay $0 copay for 1 hearing aid fitting/evaluation every three years

Out-of-Network:
You pay 50% coinsurance of the total billed cost for 1 hearing aid fitting/evaluation every three years</td></tr>
<tr><td>Hearing aids (both ears combined)</td><td>In/Out-of-Network:
$400 combined plan maximum allowance for hearing aid(s) every three years</td><td>In/Out-of-Network:
$800 combined plan maximum allowance for hearing aid(s) every three years</td></tr>
<tr><td colspan="3">Hearing aids provided by NationsHearing may have lower costs and additional hearing aid program features as follows:</td></tr>
<tr><td colspan="2">• 3 follow up visits within one year of your fitting
• Access to a nationwide network of 4,000+ trusted providers
• Brand-name hearing aids available from major manufacturers
• Concierge services by dedicated Member Services</td><td>• Three-year manufacturer’s repair warranty
• Up to 60 batteries per year
• One-time replacement coverage for lost, stolen, or damaged hearing aids
• 12- and 18-month financing options available through contracted vendor
• Available with 0% APR, no money down</td></tr>
<tr><td>Dental Services</td><td colspan="2">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.</td></tr>
<tr><td>Medicare-covered dental services</td><td>In-Network:
You pay a $40 copay per exam

Out-of-Network:
You pay a $40 copay per exam</td><td>In-Network:
You pay a $30 copay per exam

Out-of-Network:
You pay a $30 copay per exam</td></tr>
</table>

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (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. 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. Fluoride treatments are not covered.	
Routine Dental Exam	**In-Network:** You pay a $0 copay per routine dental exam Routine dental exam includes oral exam, cleaning, and one set of bitewing x-rays **Out-of-Network:** You pay 50% coinsurance of the total billed cost for a dental exam **In/Out-of-Network**: Limit of two per year - routine dental exam/cleaning and set of bitewing x-rays	
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. 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). **Pre-treatment comprehensive dental estimates are recommended before service(s) are performed.**	
Comprehensive dental services	**In-Network:** You pay 50% coinsurance of the plan allowed amount until the plan maximum is met **Out-of-Network:** You pay 50% coinsurance of the total billed cost until the plan maximum is met	

<table>
<tr><th>Health Benefits</th><th>Capital Blue Cross | WellSpan Health Advantage (PPO)</th><th>Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)</th></tr>
<tr><td>Comprehensive dental services (continued)</td><td colspan="2">In/Out-of-Network:
$2,000 combined maximum plan allowance per calendar year

The following comprehensive dental services are included:
• Teeth fillings – amalgam and composite (only)
• Simple extractions (non-surgical)
Major restorative services:
• Endodontics - includes crowns, inlays, onlays
• Prosthodontics- includes dentures, partials, bridges
• Palliative care – limited to emergency treatment and periapical x-rays
• Adjustments and repairs of prosthetics</td></tr>
<tr><td>Vision Services</td><td colspan="2">Medicare-covered vision services are exams to diagnose and treat diseases and medical conditions of the eye. Medicare-covered standard eyeglasses (or contacts lenses) are covered after each cataract surgery (does not include upgrades).</td></tr>
<tr><td>Medicare-covered vision exam and standard eyeglasses/contacts</td><td>In-Network:
You pay a $40 copay per exam

You pay $0 copay for eyeglasses or contacts after cataract surgery

Out-of-Network:
You pay a $40 copay per exam

You pay 20% coinsurance for glasses or contacts after cataract surgery</td><td>In-Network:
You pay $30 copay per exam

You pay $0 copay for eyeglasses or contacts after cataract surgery

Out-of-Network:
You pay a $30 copay per exam

You pay 20% coinsurance for glasses or contacts after cataract surgery</td></tr>
<tr><td>Annual glaucoma screening or diabetic retinal eye exam</td><td>In-Network:
You pay a $0 copay per exam

Out-of-Network:
You pay a $40 copay per diabetic exam

20% coinsurance for glaucoma screening</td><td>In-Network:
You pay a $0 copay per exam

Out-of-Network:
You pay a $30 copay per diabetic exam

20% coinsurance for glaucoma screening</td></tr>
</table>

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
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. Member is responsible for all eyewear costs once the plan maximum is met once every year. The plan will pay for either frames/lenses or contact lenses within a benefit period, but not both. Routine vision exam copays and eyewear (frames and lenses) do not apply to your maximum out-of-pocket limit (MOOP).	
Routine Eye Exam	**In-Network:** You pay a $0 copay for 1 routine eye exam every year **Out-of-Network:** Plan will reimburse the member 50% of the providers billed amount for 1 routine eye exam every year	
Standard lenses	**In-Network:** You pay $0 copay for standard single, bifocal, or trifocal eyeglass lenses from a network vision provider up to their allowed amount once every year **Out-of-Network:** Plan will reimburse the member up to our in-network provider allowed amount for eyeglass lenses (single, bifocal, trifocal) once every year	
Eyeglass frames or Contact lenses	**In/Out-of-Network**: $125 combined maximum plan allowance for eyeglass frames (or contacts in lieu of eyewear) once every year	

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Mental Health Services	**Prior authorization is required for inpatient mental health services.** 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. 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** You pay $300 copay per stay **Out-of-Network** You pay $300 copay per stay	**In-Network** You pay $275 copay per stay **Out-of-Network** You pay $275 copay per stay
Outpatient mental health therapy visit	**In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** You pay a $40 copay per visit for individual or group visits	**In-Network:** You pay a $30 copay per visit for individual or group visits **Out-of-Network:** You pay a $30 copay per visit for individual or group visits
Outpatient substance abuse visit	**In-Network:** You pay a $40 copay per visit for individual or group visits **Out-of-Network:** You pay a $40 copay per visit for individual or group visits	**In-Network:** You pay a $30 copay per visit for individual or group visits **Out-of-Network:** You pay a $30 copay per visit for individual or group visits

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
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 $188 copay per day for days 21 through 100 **Out-of-Network:** $0 copay per day for days 1 through 20 $188 copay per day for days 21 through 100 Copays indicated above are per benefit period.	**In-Network:** You pay: $0 copay per day for days 1 through 20 $188 copay per day for days 21 through 100 **Out-of-Network:** $0 copay per day for days 1 through 20 $188 copay per day for days 21 through 100 Copays indicated above are 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:** You pay a $30 copay per visit **Out-of-Network:** You pay a $30 copay per visit	**In-Network:** You pay a $30 copay per visit **Out-of-Network:** You pay a $30 copay per visit

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Ambulance	**Prior authorization required for non-emergency ambulance services.** Ambulance copay is not waived if admitted.	
Ground or air ambulance	**In-Network:** You pay a $275 copay per one-way trip **Out-of-Network:** You pay a $275 copay per one-way trip	**In-Network:** You pay a $250 copay per one-way trip **Out-of-Network:** You pay a $250 copay per one-way trip
Transportation (non-emergent)	Capital Blue Cross understands members may need assistance getting to the doctor or other medical appointments. Our plan provides round-trip transportation services (non-emergent) every year to approved locations. **Plan approved locations include:** • Doctors' offices • Outpatient facilities / centers • Clinics • Other health care related locations **A maximum of 120 miles per roundtrip.** You must receive prior approval from the plan for transportation services. Members must use plan's contracted vendor to receive transportation services. **Transportation must be scheduled two business days or more prior to the appointment.** Contact Member Services or refer to the Evidence of Coverage for more details. Transportation services do not apply to the maximum out-of-pocket.	
Transportation (non-emergent)	**In/Out-of-Network:** You pay $0 copay for **up to 8 round trips** transportation services (non- emergent) to plan-approved medical locations every year.	**In/Out-of-Network:** You pay $0 copay for **up to 24 round trips** transportation services (non- emergent) to plan-approved medical locations every year.

Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (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:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Other Part B drugs	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance

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 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 **$4,430.**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$4,430**. When you reach an out-of-pocket limit of **$4,430**, you leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

- You may get your drugs at network retail pharmacies and our mail order pharmacy.
- 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)*

Capital Blue Cross | WellSpan Health Advantage PPO	Preferred Retail and Mail Order Pharmacy 30/90 Day Supply	Standard Retail 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 (30-day supply only)	**33%** coinsurance (30-day supply only)	**33%** coinsurance (31-day supply only)
Tier 6: Select Care Drugs	**$0/ $0 copay**	**$7/ $21 copay**	**$7 copay**
Part D Insulin Saver*	**$5/ $15 copay**	**$5/ $15 copay**	**$5 copay**

Capital Blue Cross | WellSpan Health AdvantagePlus PPO	Preferred Retail and Mail Order Pharmacy 30/90 Day Supply	Standard Retail Pharmacy 30/90 Day Supply	Long Term Care Pharmacy 31 Day Supply
Tier 1: Preferred Generic Drugs	**$0/ $0 copay**	**$15/ $45 copay**	**$15 copay**
Tier 2: Generic Drugs	**$0/ $0 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 (30-day supply only)	**33%** coinsurance (30-day supply only)	**33%** coinsurance (31-day supply only)
Tier 6: Select Care Drugs	**$0/ $0 copay**	**$7/ $21 copay**	**$7 copay**
Part D Insulin Saver*	**$5/ $15 copay**	**$5/ $15 copay**	**$5 copay**

* All insulins listed on our Drug List (Formulary) are included in the Part D Insulin Saver. The most recent Drug List is on our website at (CapitalBlueMedicare.com) or contact the plan.

Individuals who qualify for Part D LIS, are not eligible to participate in the Part D Insulin Saver program and will pay their applicable LIS copays.

3. Coverage Gap Stage (Donut Hole)

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail 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 **$4,430**.

Capital Blue Cross | WellSpan Health – Advantage and AdvantagePlus (PPO) offers additional gap coverage for insulins. During the Coverage Gap stage, your out-of-pocket costs for insulins will be a $5 copay for 30 day supply. All insulins listed on our Drug List are included in the Part D Insulin Saver program. 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.

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 2022, that amount is **$7,050**. When you reach an out-of-pocket limit of **$7,050**, 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 Pharmacy

When you (or those paying on your behalf) have spent a total of **$7,050** 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 **$7,050** 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:
    - – either – coinsurance of **5%** of the cost of the drug
    - – or – **$3.95** for a generic drug or a drug that is treated like a generic and **$9.85** for all other drugs.

Additional Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Chiropractic Care	Our plan covers Medicare-covered manual manipulation of the spine to correct subluxation.	
Chiropractic visits (manual manipulation)	**In-Network:** You pay a $20 copay per visit **Out-of-Network:** You pay a $20 copay per visit	**In-Network:** You pay a $20 copay per visit **Out-of-Network:** You pay a $20 copay per visit
Diabetes Supplies and Training		
Diabetic supplies	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay a $0 copay **Out-of-Network:** You pay 20% coinsurance
Therapeutic shoes and inserts	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
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 $40 copay per visit **Out-of-Network:** You pay a $40 copay per visit	**In-Network:** You pay a $30 copay per visit **Out-of-Network:** You pay a $30 copay per visit
Home Health Care	**Prior authorization required.**	
Home health visits	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay a $0 copay per visit **Out-of-Network:** You pay 20% coinsurance

Additional Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (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 **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Prosthetics (such as braces, artificial limbs, ostomy supplies)	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Renal Dialysis (ESRD)		
Kidney dialysis	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Over the Counter (OTC) Items	Our plan gives you a monthly allowance each month to purchase over-the-counter (OTC) medications and supplies you need to stay well. OTC items include bandages, pain relievers, cold remedies, toothpaste and more. You will be able to use this monthly allowance to purchase OTC items at participating retail/pharmacy locations, such as Rite Aid, CVS, Walgreens, and Walmart. Or you will also be able to order OTC items through our mail-order vendor and have them conveniently delivered to your home Unused OTC allowance may not be carried over from one month to the next month. Please refer to the Evidence of Coverage for additional information on the OTC benefit	
OTC Allowance	$30 monthly allowance for over-the counter (OTC) drugs and supplies	

Additional Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Wellness Programs	Contact the plan or see the Evidence of Coverage for more details on Wellness programs.	
SilverSneakers® gym membership	**15,000+ Locations Across the U.S. | 70+ Fitness Classes | 1 Amazing Membership** 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 (no coverage for non SilverSneakers facilities).** To obtain a list of in network fitness centers, please see our website at www.CapitalBlueMedicare.com. **On-demand workouts:** 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. SilverSneakers fitness membership does not apply to the maximum out-of-pocket limit. SilverSneakers participating fitness centers or online services must be used. Personal trainer services are not covered.	
	You pay $0 copay for the SilverSneakers fitness program **You must use a SilverSneakers fitness facility** Members get access to all SilverSneakers fitness locations, SilverSneakers classes, on-demand videos, and perks of membership at no additional cost.	

Additional Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Wellness Programs *(continued)*	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. Counseling services can be provided by phone or in person by visiting our Capital Blue Cross Connect Stores. Health Education does not apply to the maximum out-of-pocket limit.	
	You pay $0 copay for three 30-minutes sessions per year with our Health Coaches	
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 up to 24 MNT visits for Medicare-covered conditions and for non-Medicare covered conditions to see a registered dietician or other qualified nutrition specialist with a physician's order (script) *(NOTE: our MNT visits are in addition to any Medicare-covered MNT services).* 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. MNT services must be provided by a provider licensed in nutrition or network dietician. Providers can perform MNT services in an office or via telehealth.	
	In-Network: You pay a $0 copay for medical nutritional therapy visits **Out-of-Network:** You pay 50% coinsurance for medical nutrition therapy visits	

Additional Health Benefits	Capital Blue Cross | WellSpan Health Advantage (PPO)	Capital Blue Cross | WellSpan Health AdvantagePlus (PPO)
Virtual Care Visits	From your **phone, tablet, or computer,** make an appointment to meet with a Capital Blue Cross Virtual Care doctor or behavioral health specialist. Services are provided by the plan's contracted vendor Amwell. Refer to the Evidence of Coverage for more details or contact the plan. Virtual care visits do not apply to the maximum out-of-pocket limit.	
Virtual visits	You pay $0 copay for virtual care visits received through our plan.	
PPO Network Sharing Visitor Travel Program	**Capital Blue Cross | WellSpan Health members are covered in-Network when traveling outside of the Capital Blue Cross 21-county service area.** **<u>Program Overview:</u>** **In addition to standard in- and out-of-network benefits, all Capital Blue Cross | WellSpan Health members have access to the Blue Cross Blue Shield Association Visitor and Travel Program.** When traveling outside of Capital Blue Cross' 21 county provider network, Capital Blue Cross | WellSpan Health 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. 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 47 states and 1 territory including: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, 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, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state, contact the plan for more information.	

Disclaimers:

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

On behalf of Capital Blue Cross, American Well Corp (Amwell). provides this online virtual healthcare tool. American Well is an independent company.

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

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Please call Member Services at 1-800-779-6962 (TTY: 711) for more information.

Capital

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital Blue Cross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital Blue Cross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital Blue Cross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

For help and information:

Capital Blue Cross | WellSpan Health PPO
800.990.4201

Current members
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 Cross
Medicare

Your health. Our mission.

Capital Blue Cross | WellSpan Health PPO is offered by Capital Advantage Insurance Company®, a Medicare Advantage organization with a Medicare contract.

Enrollment in Capital Blue Cross | WellSpan Health PPO depends on contract renewal. Care management services are provided by WellSpan Health. Other providers are available in the network.

Capital Blue Cross and its subsidiary Capital Advantage Insurance Company are independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

SOB22-70 (10/12/21)