HIGHMARK WHOLECARE

2024 Highmark Wholecare Benefits

Premiums and Benefits	Highmark Wholecare Medicare Assured Diamond (HMO SNP)	Highmark Wholecare Medicare Assured Ruby (HMO SNP)
Monthly Plan Premium	You pay $0	You pay $0
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $8,850 annually for in-network Medicare-covered services.	You pay no more than $6,700 annually for in-network Medicare-covered services.
Inpatient Hospital^	You pay per benefit period a: $0 copay each day for days 1-90. $0 copay each day for lifetime reserve days 91-150.	You pay per benefit period a: $250 copay each day for days 1-6. $0 copay each day for days 7-90. $0 copay each day for lifetime reserve days 91-150.
Outpatient Hospital^	You pay $0 copay for each Medicare-covered outpatient service.	Depending on the service provided, you pay between $0 copay and 20% coinsurance.
Ambulatory Surgery Center^	You pay $0 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.	You pay $200 copay per day for each Medicare-covered surgery performed in an ambulatory surgical center.
Doctor Visits		
• Primary Care	You pay $0 copay for each primary care physician visit.	You pay $0 copay for each primary care physician visit.
• Specialists	You pay $0 copay for each specialist physician visit.	You pay $25 copay for each specialist physician visit.
Preventive Care (e.g., flu vaccine, cancer screenings)	You pay $0	You pay $0
Emergency Care	You pay $0 copay for each emergency care service.	You pay $95 copay for each emergency care service. Copay is waived if admitted to hospital within 24 hours.
Urgently Needed Services	You pay $0 copay for each urgently needed service.	You pay $25 copay for each urgently needed service.

^Prior authorization may be required.

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Diagnostic Services/ Labs/Imaging^		
• Diagnostic tests and procedures/lab services	You pay $0 copay for each Medicare-covered lab service and diagnostic procedure/test.	You pay $0 copay for each Medicare-covered lab service and diagnostic procedure/test.
• MRI, CT Scan	You pay $0 copay for each Medicare-covered Advanced Imaging service.	You pay $175 copay for each Medicare-covered Advanced Imaging service.
• X-Rays	You pay $0 copay for each Medicare-covered x-ray service.	You pay $20 copay for each Medicare-covered x-ray service.
Hearing Services		
• Routine hearing exam	You pay $0 copay for one routine hearing exam per year.	You pay $0 copay for one routine hearing exam per year.
• Hearing aid allowance	You pay $0 for up to two hearing aids (one per ear) per year. Benefit is limited to TruHearing Advanced hearing aids. You must see a TruHearing provider to use this benefit.	You pay $0 for up to two hearing aids (one per ear) for three years. Benefit is limited to TruHearing Advanced hearing aids. You must see a TruHearing provider to use this benefit.
Dental Services	You receive an $8,000 allowance every year for all routine and comprehensive services. This can include most fillings; two crowns per year; any combination of up to four prophylaxis and periodontal maintenance per year, including perioprophy; dentures and denture repairs. Plan restrictions apply. See EOC for full details.	You pay $0 for one oral exam every six months; four cleanings every six months; routine x-rays once every five years; and diagnostic x-rays once every six months. You get an allowance of $3,500 every year for most fillings; one crown per year; any combination of up to four prophylaxis and periodontal maintenance per year, including perioprophy; dentures and denture repairs. Plan restrictions apply. See EOC for full details.
Vision Services		
• Routine eye exam	You pay $0 copay for one routine eye exam per calendar year.	You pay $0 copay for one routine eye exam per calendar year.
• Eyewear	You pay $0 for standard lenses and frames from the vendor collection or standard contacts, or you will have a $600 allowance toward the purchase of non-vendor frames or contact lenses. Limited lens upgrades available for $0 copay. Plan restrictions apply.	You pay $0 for standard lenses and frames from the vendor collection or standard contacts, or you will have a $200 allowance toward the purchase of non-vendor frames or contact lenses. Plan restrictions apply.
Mental Health Services		
• Outpatient group therapy/individual therapy visit	You pay $0 copay for each Medicare-covered mental health visit.	You pay $25 copay for each Medicare-covered mental health visit.

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Skilled Nursing Facility^	You pay $0 copay per day for days 1-100.	You pay $0 copay per day for days 1-20. $203 copay per day for days 21-100.
Outpatient Therapy^ • Physical, Occupational, and Speech Therapy	You pay $0	You pay $20
Ambulance^	You pay $0 copay for ground and air ambulance services.	You pay $250 copay for ground and air ambulance services.
Transportation	You pay $0 copay for routine transportation services. Routine transportation to plan approved health related locations and non-health related locations is covered in a combined limit up to 100 one-way trips per calendar year.	You pay $0 copay for routine transportation services. Routine transportation to plan approved health-related locations is covered for up to 30 one-way trips per calendar year.
General Supports for Living • Healthy Foods and Utility Support Benefit	You receive $175 per month to buy healthy foods and pay eligible utility bills. Unused funds expire at the end of each month, except for your first month of enrollment. Plan restrictions apply.	You receive $35 per month to buy healthy foods and pay eligible utility bills. Unused funds expire at the end of each month, except for your first month of enrollment. Plan restrictions apply.
Medicare Part B Drugs^	You pay $0 copay for chemotherapy and other Part B prescription drugs.	You pay $35 for Part B Insulin. You pay a 20% coinsurance of the total cost for chemotherapy and other Part B prescription drugs.
Over-the-Counter Allowance	You pay $0 copay for OTC items. $320 allowance per quarter. Unused allowance amounts expire at the end of each quarter.	You pay $0 copay for OTC items. $140 allowance per quarter. Unused allowance amounts expire at the end of each quarter.
Home-Delivered Meals	You pay $0 copay for home delivered meals. Limit of up to 28 meals (two per day) for 14 days.	You pay $0 copay for home delivered meals. Limit of up to 14 meals (two per day) for seven days.
24/7 Nurse Line	There is no coinsurance, copayment, or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week.	There is no coinsurance, copayment, or deductible for the toll-free Nurse Line. Provides telephonic coaching and nurse advice from trained clinicians, 24 hours a day, seven days a week.

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Home Safety Items	You pay $0 copay for plan approved home and bathroom safety devices. Limited to six Bathroom Safety devices per year.	You pay $0 copay for plan approved home and bathroom safety devices. Limited to two Bathroom Safety devices per year.
Personal Emergency Response System	You pay $0 copay for one personal emergency response system device per lifetime.	You pay $0 copay for one personal emergency response system device per lifetime.
Fitness Benefit	Provides membership at participating SilverSneakers fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.	Provides membership at participating SilverSneakers fitness centers at no cost. Includes at-home fitness packs and access to virtual fitness classes.
Outpatient Prescription Drugs^		
Part D Deductible	You pay $0	You pay $0
Initial Coverage Stage		
Tier 1: Preferred Generic	You pay $0 per prescription.	You pay $0 per prescription.
Tier 2: Generic	You pay $0 per prescription.	You pay $0 per prescription.
Tier 3: Preferred Brand	You pay $0 per prescription.	You pay $0 per prescription.
Tier 4: Non-Preferred	You pay $0 per prescription.	You pay $0 per prescription.
Tier 5: Specialty	You pay $0 per prescription.	You pay $0 per prescription.
Coverage Gap Stage	You pay $0 per prescription in all tiers.	You pay $0 per prescription in all tiers.
Catastrophic Coverage Stage	You pay $0 per prescription in all tiers.	You pay $0 per prescription in all tiers.

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If you want to know more about the cost and coverage of Original Medicare, look in your current "Medicare & You" handbook. You can view it online at **http://www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. **(TTY 1-877-486-2048)**

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 17 counties in northeastern Pennsylvania, 13 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.