Pennsylvania Judiciary Signature 65 with Major Medical Benefit Summary

Group #s 064230-00, -02

Signature 65 is a Medicare-complementary benefit program that fills in the coverage gaps and cost sharing of traditional Medicare (Medicare Part A and Medicare Part B). In order to enroll in Signature 65, you must be enrolled in Medicare Part A and Medicare Part B.

Medicare Part A Covered Services			
Effective	January 1, 2024		
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays (1)**
Inpatient Hospital Days 1-60	All but Part A Deductible	Medicare Part A Deductible	$0
Inpatient Hospital Days 61-90	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Inpatient Hospital Days 91-150 (may be used once per lifetime)	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Additional Inpatient Hospital Days	$0	100% of Medicare-eligible expenses for 365 additional days per benefit period, after the sixty (60) Medicare inpatient hospital lifetime reserve days are exhausted.	$0 for the first 365 additional Inpatient Hospital days per benefit period, 100% thereafter.
Skilled Nursing Facility Days 1-20	100%	$0	$0
Skilled Nursing Facility Days 21-100	All but Part A Coinsurance	Medicare Part A Coinsurance	$0
Skilled Nursing Facility Days 101 and beyond	$0	$0	100%
Blood	$0 for the first 3 pints per calendar year, 100% thereafter.	100% for the first 3 pints per calendar year, $0 thereafter.	$0
Inpatient Respite Care	95% of Part A Eligible Expenses	$0	5% of Part A Eligible Expenses
Medicare Part B Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays (1)**
Medicare Part B Covered Services (except as noted below)	All but the Part B Deductible and Part B Coinsurance	Medicare Part B Coinsurance	Medicare Part B Deductible
Blood	$0 for the first 3 pints per calendar year, 80% after the Part B Deductible thereafter.	100% for the first 3 pints per calendar year, $0 thereafter.	$0 for the first 3 pints per calendar year, 20% thereafter (if the Part B Deductible has been satisfied).
Major Medical Benefits (for services not covered by Medicare) General Provisions			
Benefit Period (2)		Calendar Year	
Deductible (per benefit period)		$100 Individual/$300 Family Non-Aggregate	
Plan Pays - Payment based on the plan allowance		80% after deductible	
Out-of-Pocket Limit (Once met, plan pays 100% for the rest of the benefit period)		$480 Individual/$1,440 Family Non-Aggregate	
Lifetime Maximum		Unlimited	
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) (3) Once met, the plan pays 100% of covered services for the rest of the benefit period.		$580 Individual/$1,740 Family Non-Aggregate	
Preventive Care (4)			
Adult			
Routine physical exams		100% (deductible does not apply)	
Adult Immunization		100% (deductible does not apply)	
Routine gynecological exams, including a PAP Test		100% (deductible does not apply)	
Colorectal Cancer Screening, routine and medically necessary		100% (deductible does not apply)	
Mammograms, as required		100% (deductible does not apply)	
Routine Foot Care - *Treatment of bunions, corns, calluses, and keratosis, cutting, trimming or removal of nails, hygienic and preventative self-care, treatment of fallen arches includes foot orthotic devices, flat or weak feet, chronic foot strain or symptomatic complaints of the feet*.		100% (deductible does not apply)	
Prostate Cancer Screening – ages 19 and over – one per benefit period		100% (deductible does not apply)	
Pediatric			
Routine physical exams		100% (deductible does not apply)	
Pediatric immunizations		100% (deductible does not apply)	
Major Medical Benefits (for services not covered by Medicare)			
Physician Office Visits including Telemedicine (5)		80% after deductible	
Emergency Care		80% after deductible	
Spinal Manipulations		80% after deductible; Limit: 30 visits/benefit period	
Physical Medicine		80% after deductible; Limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Speech Therapy		80% after deductible; Limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy		80% after deductible; Limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	

Autism Spectrum Disorders including Applied Behavior Analysis (6)	80% after deductible
Ambulance – Emergency (ground/water/air)	100% of charge for emergency transport
Ambulance – Non-Emergency (ground/water/air)	80% after deductible
Assisted Fertilization Procedures	Not Covered
Contraceptives Devices, Implants and Injectables	80% after deductible
Dental Services Related to Accidental Injury	80% after deductible
Diabetic Supplies	100% of charge (deductible does not apply)
Diabetes Treatment	80% after deductible
Diagnostic Services Advanced Imaging (including routine MRI, CAT Scan, PET scan, etc.)	80% after deductible
Basic Diagnostic Services (Standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Hearing Care Services – includes evaluation, fitting, hearing aids, repair, and maintenance of the hearing aid	100% up to $1,500 per ear maximum every 36 months (deductible does not apply)
Home Health Care	80% after deductible
Hospice	Not Covered
Hospital Services - Inpatient	80% after deductible
Hospital Services - Outpatient	80% after deductible
Infertility counseling, testing and treatment (7)	80% after deductible
Maternity (facility and professional services)	80% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible
Mental Health – Inpatient	80% after deductible
Mental Health - Outpatient	100% (deductible does not apply)
Private Duty Nursing	80% after deductible Limit: Unlimited hours/benefit period
Skilled Nursing Facility Care	80% after deductible
Substance Abuse - Inpatient	Not Covered
Substance Abuse - Outpatient	80% after deductible
Prescription Drugs	Not Covered

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) If the provider does not accept assignment from Medicare, any difference between the provider's change and the combined Medicare/Highmark payment shall be the personal responsibility of the member.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(3) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.

(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).

(5) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

(6) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.

(7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-888-269-8412.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-888-269-8412.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-888-269-8412.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-888-269-8412.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-888-269-8412.

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-888-269-8412 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-888-269-8412 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-888-269-8412.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
1-888-269-8412 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-888-269-8412.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-888-269-8412.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-888-269-8412 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-888-269-8412.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-888-269-8412.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-888-269-8412 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-888-269-8412.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-888-269-8412.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-888-269-8412 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-888-269-8412 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodiilnih 1-888-269-8412.

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