NEPMIC City of Lock Haven

Client # 220275; Group #s 10207529

Effective 1/1/2017
Renewal 1/1/2018

Signature 65 is a Medicare-complementary benefit program that fills in the coverage gaps and cost sharing of 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			
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
Medicare Part B Covered Services			
Covered Services	**Medicare Pays**	**Plan Pays**	**Member Pays(1)**
Most Medicare Part B Covered Services	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)	
Benefit Period(2)	Calendar Year
Deductible (per benefit period)	$125
Plan Pays - Payment based on the plan allowance	80% after deductible
Out-of-Pocket Limit (Once met, plan pays100% for the rest of the benefit period)	$500
Lifetime Maximum	$1,000,000
Physician Office Visits	80% after deductible
Preventive Care Adult Routine physical exams	Not Covered
Routine gynecological exams, including a PAP Test	80% (deductible does not apply)
Colorectal Cancer Screening, routine and medically necessary	80% after deductible
Mammograms, as required	80% (deductible does not apply)
Pediatric Routine physical exams	Not Covered
Pediatric immunizations	80% (deductible does not apply)
Emergency Care	80% after deductible
Spinal Manipulations	80% after deductible; Limit: 20 visits/benefit period
Physical Medicine	80% after deductible; Limit: 20 visits/benefit period
Speech Therapy	80% after deductible; Limit: 12 visits/benefit period
Occupational Therapy	80% after deductible; Limit: 12 visits/benefit period
Autism Spectrum Disorders including Applied Behavior Analysis(3)	80% after deductible

Ambulance	80% after deductible
Assisted Fertilization Procedures	Not Covered
Major Medical Benefits (for services not covered by Medicare)	
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 $5,000 maximum per benefit period. Diabetic items are excluded from this dollar maximum.
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	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	80% after deductible
Private Duty Nursing	Not Covered
Skilled Nursing Facility Care	80% after deductible
Substance Abuse - Inpatient Detoxification	80% after deductible
Substance Abuse - Inpatient Rehabilitation	80% after deductible
Substance Abuse - Outpatient	80% after deductible
Prescription Drugs	Not Covered
Prescription Drugs	
Deductible	$125
Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Open Benefit Design(4) No Mandatory Generic	**Retail Drugs (30-day Supply)** Member pays 20% after deductible **Maintenance Drugs through Mail Order (90-day Supply)** Member pays 20% after deductible

(1) If the provider does not accept assignment from Medicare, any difference between the provider's change and the combined Medicare/Highmark Blue Cross Blue Shield 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) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(4) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copay or coinsurance amounts listed above.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 claims administrator 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.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 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。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).