BlueJourney PPO

2020 SUMMARY OF BENEFITS

Public School Employees' Retirement System (PSERS)

January 1, 2020 – December 31, 2020

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 **BlueJourney PPO.**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **BlueJourney 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 http://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 http://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 **BlueJourney 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 1-866-9874213 (TTY 711).

Things to Know About BlueJourney – PPO

Hours of Operation

- From October 1 through 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 through September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

BlueJourney PPO Phone Numbers and Website

- If you are a member of this plan, call 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 **BlueJourney 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 all counties in the state of Pennsylvania and all of the United States with the exception of Maryland and Delaware.

Which doctors, hospitals, and pharmacies can I use?

BlueJourney 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. But if you want to, 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 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.

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.

Benefit	BlueJourney (PPO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
Monthly Plan Premium	Your premium is paid by your group administrator. In addition, you must keep paying your Medicare Part B premium.
Deductible	$0 deductible per year for in- network and out-of-network services. This plan does not have a deductible for Part D prescription drugs.
Maximum Out-of- Pocket Responsibility (MOOP)	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: *$3,400 for services you receive from in-network providers. Excludes Part D drugs and hearing)* $3,400 – combined for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.
Inpatient Hospital Coverage[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-Network:** $0 copayment for Medicare covered In-Hospital stays **Out-of-network:** You pay 20% coinsurance per stay A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins. *For inpatient mental health care, see the “Mental Health Care” section of this booklet.*

Benefit	BlueJourney (PPO)
Outpatient Hospital Coverage (Surgery) [1]	**Ambulatory Surgical Center:** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance **Outpatient hospital:** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance Outpatient surgery copay applies to each visit.
Doctor Visits (Primary Care Providers and Specialists) **Doctor Visits (Primary Care Providers and Specialists) continued**	**Primary care physician visit:** **In-network:** You pay a $5 copay You pay a $0 copay for Virtual Care **Out-of-network:** You pay a $5 copay **Specialist visit:** **In-network:** You pay a $15 copay You pay a $0 copay for Virtual Care **Out-of-network:** You pay a $15 copay
Health Coaching	You pay $0. • Initial 1-hour consultation with a certified Health Coach • Three 30-minute *Health Coaching/Personal Fitness*/Nutrition* sessions CapitalBLUE Health Coaches provide personalized expert advice and coaching to support you as you work towards your vision of best health. Our Health Coaches have backgrounds in a variety of health fields and are trained and certified in health coaching. Together, we can reveal your vision and approach better health by: • Recognizing your readiness for change each step of the way • Acknowledging the values that guide and motivate you towards greater health • Identifying and building on the strengths you have and exploring new skills to meet challenges • Helping you set realistic goals that are the foundation to lasting change and that build confidence **Personal Fitness is a personalized training session with a certified personal trainer, and is limited to three sessions after the initial consultation.*

<table>
<tr><th>Benefit</th><th>BlueJourney (PPO)</th></tr>
<tr><td>Preventive Care</td><td>In-network:
You pay a $0 copay

Out-of-network:
You pay 20% coinsurance

Our plan covers many preventive services, including:
• Abdominal aortic aneurysm screening
• Alcohol misuse counseling
• Bone mass measurement
• Breast cancer screening (mammogram)
• Cardiovascular disease (behavioral therapy)
• Cardiovascular screenings
• Cervical and vaginal cancer screening
• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
• Depression screening
• Diabetes screenings
• HIV screening
• Medical nutrition therapy services
• Obesity screening and counseling
• Prostate cancer screenings (PSA)
• Sexually transmitted infections screening and counseling
• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
• “Welcome to Medicare” preventive visit (one-time)
• Yearly “Wellness” visit

Any additional preventive services approved by Medicare during the contract year will be covered.</td></tr>
<tr><td>Emergency Coverage

Worldwide Emergency Coverage

Worldwide Maximum Annual Plan Benefit</td><td>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

$200,000 maximum annual benefit – Combined for Emergency and Urgent Care Coverage

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</td></tr>
</table>

Benefit	BlueJourney (PPO)
Urgently Needed Services **Worldwide Urgently Needed Services**	**In/Out-of-Network:** You pay a $35 copay per visit (within the U.S.) You pay $0 copay for Virtual Care **In/Out-of-Network:** You pay a $35 copay per visit (Worldwide)
Diagnostic Services/Labs / Imaging – Outpatient (Costs for these services may vary based on place of service) [1] **Diagnostic Services/Labs / Imaging – Outpatient** (Costs for these services may vary based on place of service) continued[1]	**Diagnostic radiology services (**such as MRIs, CT scans**):** **In-network:** You pay a $25 copay **Out-of-network**: You pay a $25 copay **Diagnostic tests and procedures:** **In-network:** You pay a $0 copay **Out-of-network:** You pay a $0 copay **Lab services:** **In-network:** $10 copay lab services **Out-of-network:** $10 copay lab services **Outpatient X-rays:** **In-network:** You pay a $0 copay **Out-of-network:** You pay a $0 copay **Therapeutic radiology services (such as radiation treatment for cancer):** **In-network:** You pay 15% coinsurance **Out-of-network:** You pay 15% coinsurance
Hearing Services	**Exam to diagnose and treat hearing and balance issues:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Routine hearing exam (for up to 1 every year):** **In-network:** You pay a $0 copay **Out-of-network:** You pay 50% coinsurance, applied to charge

Benefit	BlueJourney (PPO)
Hearing Services continued	**Hearing aid fitting/evaluation (for up to 1 every three years):** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance, applied to charges **Hearing aid:** **In-and-out-of-network:** You pay a $0 copay $500 maximum plan allowance every three years for hearing aids.
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **In-network:** You pay a $15 copay **Out-of-network:** You pay 50% coinsurance Medicare-covered dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician. Routine dental services: $15 copay for one routine dental visit every 6 months includes: • Cleaning • Bitewing X-rays (Set of 2) • Oral exam Fluoride treatments excluded. Out-of-network: You pay 50% coinsurance per office visit **In-Network** 50% Coinsurance applied to plan allowed amounts for the following services: • Dentures • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays)

Benefit	BlueJourney (PPO)
Dental Services continued[1]	• Prosthodontics • Adjustments and Repairs of Prosthetics $1,500 maximum plan allowance per calendar year, applies to both in-network and out-of-network services. **Out-of-network:** 50% Coinsurance applied to provider billed amounts for non-routine dental services: • Dentures • Palliative Emergency Treatment • Periapical X-rays • Amalgam and Composite Fillings • Simple (Non-Surgical) Extractions • Endodontics • Major Restorative (Crowns, Inlays, Onlays) • Prosthodontics • Adjustments and Repairs of Prosthetics Prior authorization required for Medicare-covered dental services. **Pre-Treatment Estimates are recommended before service is performed.**
Vision Services[1]	**Exam to diagnose and treat diseases and conditions of the eye:** **In-network:** You pay a $15 copay **Out-of-network:** You pay 20% coinsurance **Annual glaucoma screening for those at risk:** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance **Routine Eye Exams** **In network:** One routine exam every calendar year. $20 copay **Routine Eye Exams** **Out of network:** Plan reimburses the member 50% of the providers billed amount for one routine exam. **Eyeglass Frames In-network:** One frame every 2 calendar years.

Benefit	BlueJourney (PPO)
Vision Services continued[1]	Members pay the balance of charges after a $40 allowance is applied. **Eyeglass Frames Out-of-network:** Plan reimburses the member $40 of the providers billed amount for one frame every 2 years. **Standard Eyeglass Lenses In-network:** One pair of lenses every 2 calendar years Plan pays 100% **Standard Eyeglass Lenses Out-of-network:** Plan reimburses the member up to the allowances for one pair of lenses every 2 years listed below: • Single vision $36 • Bi-focal $48 • Tri-focal $58 **Elective Contact Lenses In-network:** One order as prescribed every 2 calendar years Members pay the balance of charges after a $40 allowance is applied. **Elective Contact Lenses Out-of-network:** Plan reimburses the member $40 of the providers billed amount. Payment will be made for either lenses or contact lenses within a benefit period. Payment will not be made for both.
Mental Health Care[1] **Mental Health Care continued**[1]	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins. **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance per stay

Benefit	BlueJourney (PPO)
Outpatient Mental Health Services[1] **Outpatient Substance Abuse**[1]	**Outpatient group therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Outpatient individual therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Group therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Individual therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay
Skilled Nursing Facility (SNF) 1	**Our plan covers up to 100 days in a SNF.** **In-network:** You pay a $0 copay per day for days 1 through 10 You pay a $25 copay per day for days 11 through 100 **Out-of-network:** 20% of the cost per stay A benefit period begins the day you go into a skilled nursing facility (SNF). The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins.
Outpatient Rehabilitation[1]	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay

Benefit	BlueJourney (PPO)
Outpatient Rehabilitation continued[1]	**Intensive cardiac (heart) rehab** services sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks: **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Pulmonary rehab services:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Occupational therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay **Physical therapy and speech and language therapy visit:** **In-network:** You pay a $15 copay **Out-of-network:** You pay a $15 copay
Ambulance[1]	**In/Out-of-network:** You pay a $70 copay Prior authorization required for non-emergency services.
Transportation	**Not** Covered
Medicare Part B Drugs (e.g. chemotherapy drugs)[1]	**For Part B drugs such as chemotherapy drugs:** **In-network:** You pay 15% coinsurance **Out-of-network:** You pay 20% coinsurance **Other Part B drugs**[1]**:** **In-network:** You pay 15% coinsurance **Out-of-network:** You pay 20% coinsurance

Benefit	BlueJourney (PPO)
Foot Care (podiatry services) [1]	**Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:** **In-network:** You pay a $15 copay **Out-of-network:** You pay 20% coinsurance If a primary care physician provides the Foot Care services, a $5 copay would apply. Otherwise, a $15 copay would apply.
Durable Medical Equipment (e.g. wheelchairs, oxygen, etc.) [1] **Diabetes Supplies and Services**[1]	**In-network:** You pay 15% coinsurance **Out-of-network:** You pay 15% coinsurance **Diabetes monitoring supplies:** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance **Diabetes self-management training:** **In-network:** You pay a $0 copay **Out-of-network**: You pay 20% coinsurance **Therapeutic shoes or inserts:** **In-network:** You pay a $0 copay **Out-of-network:** You pay 20% coinsurance
Prosthetic Devices[1]	**Prosthetic devices:** **In-network:** You pay 15% coinsurance **Out-of-network:** You pay 20% coinsurance **Related medical supplies:** **In-network:** You pay 15% coinsurance **Out-of-network:** You pay 20% coinsurance

Benefit	BlueJourney (PPO)
Renal Dialysis[1]	**Dialysis Services:** **In-network:** You pay 20% coinsurance **Out-of-network:** You pay 20% coinsurance
Wellness Programs (e.g. fitness)	**Fitness Club membership** (Silver&Fit) **In-network:** You pay a $0 copay **Out-of-network:** You pay 50% coinsurance, applied to charges
Home Health Care[1]	**In-network:** You pay a $0 copay per visit **Out-of-network:** You pay 20% coinsurance per visit
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. You pay a $0 copay per visit for Hospice consultation. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.
Acupuncture	**Not** Covered
Over-the-Counter Drugs and Supplies	$15 monthly allowance for Over-the-Counter (OTC) drugs and supplies. Unused allowance may not be carried over from one month to the next. Please visit our website to see our list of covered Over-the-Counter (OTC) items offered through an external vendor.

Benefit	BlueJourney PPO
Initial Coverage	You pay the following until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020. 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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: '5% of the cost, or '$3.60 copay for generic (including brand drugs treated as generic) and an $8.95 copayment for all other drugs.

Benefit	BlueJourney PPO		
Initial Coverage	Retail Cost-Sharing		
	Tier	One-month supply	Three-month supply
	Tier 1 Preferred Generic	$4 copay	$12 copay
	Tier 2 Generic	$12 copay	$36 copay
	Tier 3 Preferred Brand	$38 copay	$114 copay
	Tier 4 Non-Preferred	$90 copay	$270 copay
	Tier 5 Specialty	33% coinsurance	Not Offered
	Mail Order Cost-Sharing		
	Tier	One-month supply	Three-month supply
	Tier 1 Preferred Generic	$4 copay	$12 copay
	Tier 2 Generic	$12 copay	$36 copay
	Tier 3 Preferred Brand	$38 copay	$114 copay
	Tier 4 Non-Preferred	$90 copay	$270 copay
	Tier 5 Specialty	33% coinsurance	Not Offered

Capital BLUE

Capital BlueCross is an Independent Licensee
of the BlueCross BlueShield Association

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross 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 BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross 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 BlueCross 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 BlueCross
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).

무료전화통역서비스800.962.2242 (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).

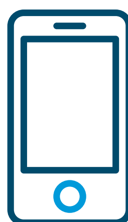
દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

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:

BlueJourney PPO
1-800-990-4201

Current members
1-866-987-4213 (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

www.CapitalBlueMedicare.com

BlueJourney PPO is offered by Capital Advantage Insurance Company®, a Medicare Advantage organization with a Medicare contract. Enrollment in BlueJourney PPO depends on contract renewal.

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

SOB20-54 (11/07/19)