HIGHMARK®
Freedom Blue PPO

Freedom Blue PPO

2015 Summary of Benefits

Western Pennsylvania

H3916_14_0228 Accepted

Freedom Blue PPO, ValueRx (PPO), Select (PPO) and Classic (PPO)

January 1, 2015 – December 31, 2015

PENNSYLVANIA

HIGHMARK® Freedom Blue PPO

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 **Freedom Blue PPO ValueRx (PPO), Select (PPO) and Classic (PPO)**).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Freedom Blue PPO ValueRx (PPO), Select (PPO) and Classic (PPO)** cover 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 **Freedom Blue PPO ValueRx (PPO), Select (PPO) and Classic (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 (800)-550-8722. (TTY/TDD 711)

THINGS TO KNOW ABOUT FREEDOM BLUE PPO VALUERX (PPO), SELECT (PPO) AND CLASSIC (PPO)

HOURS OF OPERATION

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

FREEDOM BLUE PPO VALUERX (PPO), SELECT (PPO) AND CLASSIC (PPO) PHONE NUMBERS AND WEBSITE

• If you are a member of this plan, call toll-free (800)-550-8722. (TTY/TDD 711)

• If you are not a member of this plan, call toll-free (866)-682-7971. (TTY/TDD (800)-227-8210)

• Our website: http://www.highmarkblueshield.com/medicare

WHO CAN JOIN?

To join **Freedom Blue PPO ValueRx (PPO), Select (PPO) and Classic (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 counties in Pennsylvania: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland in Southwestern PA and Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, and Warren in West Central PA.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Freedom Blue PPO ValueRx (PPO), Select (PPO) and Classic (PPO) have 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.

If you have any questions about this plan's benefits or costs, please contact Highmark Inc. for details.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
You can see our plan's provider and pharmacy directory at our website (http://www.highmarkblueshield.com/medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

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, client.formularynavigator.com/clients/hm/default.html.

- 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.

HIGHMARK®

Freedom Blue PPO

If you have any questions about this plan's benefits or costs, please contact Highmark Inc. for details.

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
How much is the monthly premium?	$105-123 per month. In addition, you must keep paying your Medicare Part B premium.	$137-184 per month. In addition, you must keep paying your Medicare Part B premium. premium?	$280-319 per month. In addition, you must keep paying your Medicare Part B premium. premium?
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	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: • $6,700 for services you receive from in-network providers. • $10,000 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.	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: • $6,700 for services you receive from in-network providers. • $10,000 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.	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: • $6,700 for services you receive from in-network providers. • $10,000 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.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

COVERED MEDICAL AND HOSPITAL BENEFITS			
	NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION. SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.	**NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION. SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	**NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION. SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**
OUTPATIENT CARE AND SERVICES			
Acupuncture and Other Alternative Therapies	Not covered	Not covered	Not covered
Ambulance	• In-network: $200 copay • Out-of-network: $200 copay or 30% of the cost, depending on the service	• In-network: $150 copay • Out-of-network: $150 copay or 30% of the cost, depending on the service	• In-network: $100 copay • Out-of-network: $100 copay or 30% of the cost, depending on the service
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 30% of the cost Routine chiropractic visit (for up to 8 every year): • In-network: $20 copay • Out-of-network: 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 30% of the cost Routine chiropractic visit (for up to 8 every year): • In-network: $20 copay • Out-of-network: 30% of the cost
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

If you have any questions about this plan's benefits or costs, please contact Highmark Inc. for details.

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			

Dental Services[1] (continued)	• In-network: $40-300 copay, depending on the service
	• Out-of-network: 30% of the cost
	
	Preventive dental services:
	• Dental x-ray(s) (for up to 1 every year):
	  • In-network: $25 copay
	  • Out-of-network: 50% of the cost
	
	A single office visit that includes:
	• Cleaning (for up to 1 every year)
	• Oral exam (for up to 1 every year)
	  • In-network: $30 copay
	  • Out-of-network: 50% of the cost
		• In-network: $35-250 copay, depending on the service
		• Out-of-network: 30% of the cost
		
		Preventive dental services:
		• Dental x-ray(s) (for up to 1 every year):
		  • In-network: $25 copay
		  • Out-of-network: 50% of the cost
		
		A single office visit that includes:
		• Cleaning (for up to 1 every year)
		• Oral exam (for up to 1 every year)
		  • In-network: $30 copay
		  • Out-of-network: 50% of the cost
			• In-network: $25-250 copay, depending on the service
			• Out-of-network: 30% of the cost
			
			Preventive dental services:
			• Dental x-ray(s) (for up to 1 every year):
			  • In-network: $20 copay
			  • Out-of-network: 50% of the cost
			
			A single office visit that includes:
			• Cleaning (for up to 1 every year)
			• Oral exam (for up to 1 every year)
			  • In-network: $20 copay
			  • Out-of-network: 50% of the cost

Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 30% of the cost	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 30% of the cost	Diabetes monitoring supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 30% of the cost

Diabetes Supplies and Services[1] (continued)	Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 30% of the cost
Diagnostic Tests, Lab and Radiology Services, and XRays[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $200 copay • Out-of-network: 30% of the cost Diagnostic tests and procedures: • In-network: $5-15 copay, depending on the service • Out-of-network: 30% of the cost Lab services: • In-network: $5-15 copay, depending on the service • Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $150 copay • Out-of-network: 30% of the cost Diagnostic tests and procedures: • In-network: $0-10 copay, depending on the service • Out-of-network: 30% of the cost Lab services: • In-network: $0-10 copay, depending on the service • Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $100 copay • Out-of-network: 30% of the cost Diagnostic tests and procedures: • In-network: You pay nothing • Out-of-network: 30% of the cost Lab services: • In-network: You pay nothing • Out-of-network: 30% of the cost

If you have any questions about this plan's benefits or costs, please contact Highmark Inc. for details.

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			
Diagnostic Tests, Lab and Radiology Services, and XRays[1] (continued)	Outpatient x-rays: • In-network: $50 copay • Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 30% of the cost	Outpatient x-rays: • In-network: $40 copay • Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 30% of the cost	Outpatient x-rays: • In-network: $20 copay • Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 30% of the cost
Doctor's Office Visits	Primary care physician visit: • In-network: $15 copay • Out-of-network: $30 copay Specialist visit: • In-network: $40 copay • Out-of-network: $50 copay	Primary care physician visit: • In-network: $10 copay • Out-of-network: $30 copay Specialist visit: • In-network: $35 copay • Out-of-network: $45 copay	Primary care physician visit: • In-network: $5 copay • Out-of-network: $30 copay Specialist visit: • In-network: $25 copay • Out-of-network: $40 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	• In-network: 20% of the cost • Out-of-network: 30% of the cost	• In-network: 20% of the cost • Out-of-network: 30% of the cost	• In-network: 20% of the cost • Out-of-network: 30% of the cost
Emergency Care	$65 copay If you are admitted to the hospital within 3 days, 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.	$65 copay If you are admitted to the hospital within 3 days, 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.	$65 copay If you are admitted to the hospital within 3 days, 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.

Foot Care *(podiatry services)*	Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $40 copay • Out-of-network: 30% of the cost	Foot Care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $35 copay • Out-of-network: 30% of the cost Routine foot care (for up to 10 visit(s) every year): • In-network: $35 copay • Out-of-network: 30% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $25 copay • Out-of-network: 30% of the cost Routine foot care (for up to 10 visit(s) every year): • In-network: $25 copay • Out-of-network: 30% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $40 copay • Out-of-network: 30% of the cost Routine hearing exam (for up to 1 every year): • In-network: $40 copay • Out-of-network: 30% of the cost Hearing aid: • In-network:You pay nothing • Out-of-network: You pay nothing Our plan pays up to $500 every three years for hearing aids from any provider.	Exam to diagnose and treat hearing and balance issues: • In-network: $35 copay • Out-of-network: 30% of the cost Routine hearing exam (for up to 1 every year): • In-network: $35 copay • Out-of-network: 30% of the cost Hearing aid: • In-network:You pay nothing • Out-of-network: You pay nothing Our plan pays up to $500 every three years for hearing aids from any provider.	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: 30% of the cost Routine hearing exam (for up to 1 every year): • In-network: $25 copay • Out-of-network: 30% of the cost Hearing aid: • In-network:You pay nothing • Out-of-network: You pay nothing Our plan pays up to $500 every three years for hearing aids from any provider.

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BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: 30% of the cost	• In-network: You pay nothing • Out-of-network: 30% of the cost	• In-network: You pay nothing • Out-of-network: 30% of the cost

Mental Health Care[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.
	
	• In-network:
	  • $250 copay per day for days 1 through 5
	  • You pay nothing per day for days 6 through 90
	• Out-of-network:
	  • 30% of the cost per stay
		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.
		
		• In-network:
		  • $200 copay per day for days 1 through 5
		  • You pay nothing per day for days 6 through 90
		• Out-of-network:
		  • 30% of the cost per stay
			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.
			
			• In-network:
			  • $125 copay per day for days 1 through 5
			  • You pay nothing per day for days 6 through 90
			• Out-of-network:
			  • 30% of the cost per stay

Mental Health Care[1] (continued)	Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost Outpatient individual therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost	Outpatient group therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost Outpatient individual therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost	Outpatient group therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost Outpatient individual therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost
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 nothing • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost	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 nothing • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost	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 nothing • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost

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BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			
Outpatient Substance Abuse[1]	Group therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost Individual therapy visit: • In-network: $40 copay • Out-of-network: 30% of the cost	Group therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost Individual therapy visit: • In-network: $35 copay • Out-of-network: 30% of the cost	Group therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost Individual therapy visit: • In-network: $25 copay • Out-of-network: 30% of the cost
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $200 copay • Out-of-network: 30% of the cost Outpatient hospital: • In-network: $300 copay • Out-of-network: 30% of the cost	Ambulatory surgical center: • In-network: $150 copay • Out-of-network: 30% of the cost Outpatient hospital: • In-network: $250 copay • Out-of-network: 30% of the cost	Ambulatory surgical center: • In-network: $150 copay • Out-of-network: 30% of the cost Outpatient hospital: • In-network: $250 copay • Out-of-network: 30% of the cost
Over-the-Counter Items	Not Covered	Not Covered	Not Covered
Prosthetic Devices (braces, artificial limbs, etc.)[1]	Prosthetic Devices: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Prosthetic Devices: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Prosthetic Devices: • In-network: 20% of the cost • Out-of-network: 30% of the cost

Prosthetic Devices (braces, artificial limbs, etc.)[1] (continued)	Related medical supplies: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Related medical supplies: • In-network: 20% of the cost • Out-of-network: 30% of the cost	Related medical supplies: • In-network: 20% of the cost • Out-of-network: 30% of the cost
Renal Dialysis	• In-network: You pay nothing • Out-of-network: 0-30% of the cost, depending on the service	• In-network: You pay nothing • Out-of-network: 0-30% of the cost, depending on the service	• In-network: You pay nothing • Out-of-network: 0-30% of the cost, depending on the service
Transportation	• In-network: $40 copay • Out-of-network: 50% of the cost	• In-network: $40 copay • Out-of-network: 50% of the cost	• In-network: $40 copay • Out-of-network: 50% of the cost
Urgent Care	$50 copay	$50 copay	$50 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-40 copay, depending on the service • Out-of-network: 30% of the cost Routine eye exam (for up to 1 every year): • In-network: You pay nothing • Out-of-network: 30% of the cost Contact lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-35 copay, depending on the service • Out-of-network: 30% of the cost Routine eye exam (for up to 1 every year): • In-network: You pay nothing • Out-of-network: 30% of the cost Contact lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: 30% of the cost Routine eye exam (for up to 1 every year): • In-network: You pay nothing • Out-of-network: 30% of the cost Contact lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing

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BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			
Vision Services (continued)	Our plan pays up to $100 every year for contact lenses from any provider. Eyeglass frames (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass frames from any provider. Eyeglass lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass lenses from any provider. Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 30% of the cost	Our plan pays up to $100 every year for contact lenses from any provider. Eyeglass frames (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass frames from any provider. Eyeglass lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass lenses from any provider. Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 30% of the cost	Our plan pays up to $100 every year for contact lenses from any provider. Eyeglass frames (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass frames from any provider. Eyeglass lenses (for up to 1 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for eyeglass lenses from any provider. Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: 30% of the cost
Preventive Care	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including:	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including:	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including:

Preventive Care (continued)	• 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling	• 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling	• 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
OUTPATIENT CARE AND SERVICES			
Preventive Care (continued)	(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.	(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.	(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.
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.	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.	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.
INPATIENT CARE			

Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay.
	• In-network:
	  • $250 copay per day for days 1 through 5
	  • You pay nothing per day for days 6 through 90
	  • You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  • 30% of the cost per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
		• In-network:
		  • $200 copay per day for days 1 through 5
		  • You pay nothing per day for days 6 through 90
		  • You pay nothing per day for days 91 and beyond
		• Out-of-network:
		  • 30% of the cost per stay
			Our plan covers an unlimited number of days for an inpatient hospital stay.
			• In-network:
			  • $125 copay per day for days 1 through 5
			  • You pay nothing per day for days 6 through 90
			  • You pay nothing per day for days 91 and beyond
			• Out-of-network:
			  • 30% of the cost per stay

Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF.
	• In-network:
	  • $0 copay per day for days 1-20
	  • $150 copay per day for days 21-100
	• Out-of-network:
	  • 30% of the cost per stay
		Our plan covers up to 100 days in a SNF.
		• In-network:
		  • $0 copay per day for days 1-20
		  • $150 copay per day for days 21-100
		• Out-of-network:
		  • 30% of the cost per stay
			Our plan covers up to 100 days in a SNF.
			• In-network:
			  • $0 copay per day for days 1-20
			  • $150 copay per day for days 21-100
			• Out-of-network:
			  • 30% of the cost per stay

PRESCRIPTION DRUG BENEFITS			
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug Other Part B drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug	For Part B drugs such as chemotherapy drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug Other Part B drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug	For Part B drugs such as chemotherapy drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug Other Part B drugs[1]: • In-network: 0-20% of the cost depending on the drug • Out-of-network: 0-30% of the cost, depending on the drug
Initial Coverage	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
PRESCRIPTION DRUG BENEFITS			
Initial Coverage (continued)	You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing** **One-month supply** Tier 1 (Preferred Generic) $4 copay Tier 2 (Non-Preferred Generic) $15 copay Tier 3 (Preferred Brand) $45 copay Tier 4 ((Non-Preferred Brand) $95 copay Tier 5 (Specialty Tier) 33% of the cost **Three-month supply** Tier 1 (Preferred Generic) $12 copay Tier 2 (Non-Preferred Generic) $45 copay Tier 3 (Preferred Brand) $135 copay Tier 4 ((Non-Preferred Brand) $285 copay Tier 5 (Specialty Tier) 33% of the cost	You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing** **One-month supply** Tier 1 (Preferred $4 copay Tier 2 (Non-Preferred Generic) $12 copay Tier 3 (Preferred Brand) $45 copay Tier 4 ((Non-Preferred Brand) $95 copay Tier 5 (Specialty Tier) 33% of the cost **Three-month supply** Tier 1 (Preferred Generic) $12 copay Tier 2 (Non-Preferred Generic) $36 copay Tier 3 (Preferred Brand) $135 copay Tier 4 ((Non-Preferred Brand) $285 copay Tier 5 (Specialty Tier) 33% of the cost	You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing** **One-month supply** Tier 1 (Preferred $4 copay Tier 2 (Non-Preferred Generic) $12 copay Tier 3 (Preferred Brand) $45 copay Tier 4 ((Non-Preferred Brand) $90 copay Tier 5 (Specialty Tier) 33% of the cost **Three-month supply** Tier 1 (Preferred Generic) $12 copay Tier 2 (Non-Preferred Generic) $36 copay Tier 3 (Preferred Brand) $135 copay Tier 4 ((Non-Preferred Brand) $270 copay Tier 5 (Specialty Tier) 33% of the cost

Initial Coverage (continued)	**Standard Mail Order Cost-Sharing** **Three-month supply** Tier 1 (Preferred Generic) $10 copay Tier 2 (Non-Preferred Generic) $37.50 copay Tier 3 (Preferred Brand) $112.50 copay Tier 4 (Non-Preferred Brand) $237.50 copay Tier 5 (Specialty Tier) 33% of the cost 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.	**Standard Mail Order Cost-Sharing** **Three-month supply** Tier 1 (Preferred Generic) $10 copay Tier 2 (Non-Preferred Generic) $30 copay Tier 3 (Preferred Brand) $112.50 copay Tier 4 (Non-Preferred Brand) $237.50 copay Tier 5 (Specialty Tier) 33% of the cost 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.	**Standard Mail Order Cost-Sharing** **Three-month supply** Tier 1 (Preferred Generic) $10 copay Tier 2 (Non-Preferred Generic) $30 copay Tier 3 (Preferred Brand) $112.50 copay Tier 4 (Non-Preferred Brand) $225 copay Tier 5 (Specialty Tier) 33% of the cost 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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the 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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the 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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

BENEFIT CATEGORY	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)	Freedom Blue PPO Classic (PPO)
PRESCRIPTION DRUG BENEFITS			
Coverage Gap (continued)			Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard Retail Cost-Sharing** **Drugs Covered** All **One-month supply** Tier 1 (Preferred Generic) $4 copay Tier 2 (Non-Preferred Generic) $12 copay **Three-month supply** Tier 1 (Preferred Generic) $12 copay Tier 2 (Non-Preferred Generic) $36 copay **Standard Mail Order Cost-Sharing** **Drugs Covered** All **Three-month supply** Tier 1 (Preferred Generic) $10 copay Tier 2 (Non-Preferred Generic) $30 copay

Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

If you have any questions about this plan's benefits or costs, please contact Highmark Inc. for details.

PREMIUM TABLE

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve.
The service area for Southwestern, PA includes the following counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland.

The service area for West Central, PA includes the following counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, and Warren.

	Southwestern, PA	West Central, PA
Freedom Blue ValueRx (PPO)	$123	$105
Freedom Blue Select (PPO)	$184	$137
Freedom Blue Classic (PPO)	$319	$280

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-456-3738. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-456-3738. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-456-3738。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-456-3738。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-456-3738. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-456-3738. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-456-3738 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-456-3738. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-456-3738 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-456-3738. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا بمساعدتك. هذه خدمة مجانية على 1-668-654-8373 سيقوم شخص ما يتحدث العربية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-456-3738. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-456-3738. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-456-3738. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-456-3738. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-456-3738 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-456-3738 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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