Freedom Blue PPO sponsored by The Pennsylvania State University (Group # 178428) offered by Highmark Senior Health Company

Annual Notice of Changes for 2018

You are currently enrolled as a member of Freedom Blue PPO. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **As a member of an employer group or trust fund, you may choose to leave your group plan and select an Individual Medicare Advantage plan or Part D Prescription Drug plan. The Medicare enrollment period is from October 15 until December 7. However, you may have a Special Election Period (SEP) and may enroll until December 31.**

What to do now

1. ASK: Which changes apply to you

□ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.2 and 1.5 for information about benefit and cost changes for our plan.

□ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?

- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

□ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

□ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

□ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

□ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

□ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan

- If you want to **keep** Freedom Blue PPO through your former employer/trust fund, you don't need to do anything. You will stay in Freedom Blue PPO through your former employer/trust fund.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Freedom Blue PPO through your former employer/trust fund.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- Please contact our Customer Service number at 1-866-918-5285 for additional information. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
- This information is available in an alternate format.

- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Freedom Blue PPO

- Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Highmark Senior Health Company. When it says "plan" or "our plan," it means Freedom Blue PPO.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Freedom Blue PPO in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes,*** including the *Medical Benefit Chart* and *Part D Prescription Drugs*, and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $500 From network and out-of-network providers combined: $ 750	From network providers: $500 From network and out-of-network providers combined: $ 750
Doctor office visits	Primary care visits: Network: $10 copay per visit Out-of-Network: 10% of the total cost of the visit Specialist visits: Network: $20 copay per visit Out-of-Network: 10% of the total cost of the visit	Primary care visits: Network: $10 copay per visit Out-of-Network: 10% of the total cost of the visit Specialist visits: Network: $20 copay per visit Out-of-Network: 10% of the total cost of the visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Network: 0% of the total cost Out-of-Network: 10% of the total cost	Network: 0% of the total cost Out-of-Network: 10% of the total cost
Part D prescription drug coverage	Deductible: $0	Deductible: $0

Cost	2017 (this year)	2018 (next year)
(See Section 1.6 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay • **Drug Tier 5:** $50 copay	Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay • **Drug Tier 5:** $50 copay

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

You do not pay a monthly premium to Highmark Senior Health Company for your Freedom Blue PPO plan.

If you pay a premium through your former employer or trust fund:

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if applicable) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium (if applicable) and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$500	$500 Once you have paid $500 out-of-pocket for covered Part A and Part B services, you may pay nothing, depending on your plan, for your covered Part A and Part B services from network providers for the rest of the calendar year, except copayments if applicable.
Combined maximum out-of-pocket amount	$750	$750

Cost	2017 (this year)	2018 (next year)
Your costs for covered medical services (such as copays and deductibles if applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) does not count toward your maximum out-of-pocket amount.		Once you have paid $750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.highmarkblueshield.com/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2018 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Blue Cross Blue Shield Association Network Sharing

Participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are available in 35 states and Puerto Rico. Please see Chapter 3, Section 2.3 as well as the Appendix titled *Network Sharing*, in the *Evidence of Coverage* for more details on Blue Cross and/or Blue Shield Medicare Advantage PPO network sharing.

Freedom Blue PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider and pay network cost-sharing. If you are in a network-sharing county and see a non-network provider, you will pay higher cost-sharing.

If your medical service is received in a county that does not participate in the Blue Cross and/or Blue Shield Medicare Advantage PPO Network, you can visit any provider that participates with Medicare and pay the in-network cost-sharing amount.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.highmarkblueshield.com/medicare. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2018 *Provider/Pharmacy Directory* to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see the *Medical Benefits Chart* appendix in the back of this booklet.

	2017 (this year)	2018 (next year)
Transportation	Mode of transportation included taxi, bus and subway.	Mode of transportation is limited to van, medical transport, wheelchair van or car.
Telemedicine	Not covered.	For PCP visits Post-Discharge Medication Reconciliation: Provides access to in-network follow-up visits via web and phone-based technologies if offered. Network: You pay a $10 copayment per visit. Out-of-Network: Not covered.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are currently taking a drug that Highmark Senior Health Company approved as a formulary exception in 2017, you may need to ask for a new formulary exception for the same drug in 2018.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2017, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* and the *Part D Prescription Drugs* appendix in the back of this booklet for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage (if applicable) and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage* and the *Part D Prescription Drugs* appendix in the back of this booklet.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage	Because there is no deductible, this payment stage does not apply to you.	Because there is no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage* and the *Part D Prescription Drugs* appendix in the back of this booklet.

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:

Stage	2017 (this year)	2018 (next year)
The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage* and in the *Part D Prescription Drugs* Appendix in the back of this booklet. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	pharmacy with standard cost-sharing: ***Tier 1 Preferred Generic:*** You pay $12 per prescription. ***Tier 2 Generic:*** You pay $12 per prescription. ***Tier 3 Preferred Brand:*** You pay $20 per prescription. ***Tier 4 Non-Preferred Drug:*** You pay $50 per prescription. ***Tier 5 Specialty:*** You pay $50 per prescription. Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	***Tier 1 Preferred Generic:*** You pay $12 per prescription. ***Tier 2 Generic:*** You pay $12 per prescription. ***Tier 3 Preferred Brand:*** You pay $20 per prescription. ***Tier 4 Non-Preferred Drug:*** You pay $50 per prescription. ***Tier 5 Specialty:*** You pay $50 per prescription. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage* and the *Part D Prescription Drug* appendix in the back of this booklet.

SECTION 2 Administrative Changes

Process	2017 (this year)	2018 (next year)
Step Therapy	No requirement to try a less costly drug, that is just as effective, if a more costly drug is initially prescribed.	If a member is prescribed a drug from the formulary that is more costly than another prescription with the same expected outcome for the same medical condition, members will be required to try less costly, but just as effective, drugs before the plan covers another drug.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Freedom Blue PPO

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 31, you will automatically stay enrolled as a member of our plan for 2018.

Section 3.2 – If you want to change plans

Since you receive your Freedom Blue PPO coverage through your former employer or trust fund, it is important that you check with your former employer or trust fund before making any changes or switching to a plan not offered by your former employer or trust fund.

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- Since you receive your Freedom Blue PPO coverage through your former employer or trust fund, it is important that you check with your former employer or trust fund before making any changes. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.
- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Freedom Blue PPO.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Freedom Blue PPO.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 31.** The change will take effect on January 1, 2018.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. Please refer to the *Agency Contact Information* appendix in the back of your *Evidence of Coverage* booklet for a list of SHIP contact information by state.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Many states have a program called State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in the *Agency Contact Information* appendix in the back of your *Evidence of Coverage* booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through your state's ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please see the *Agency Contact Information* appendix in the back of the accompanying booklet and call your state-specific program.

SECTION 7 Questions?

Section 7.1 – Getting Help from Freedom Blue PPO

Questions? We're here to help. Please call Customer Service at 1-866-918-5285. (TTY only, call 711 National Relay Service.) We are available for phone calls Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Calls to these numbers are free.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Freedom Blue PPO and the *Medical Benefits Chart* appendix in the back of this booklet. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.highmarkblueshield.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2018*

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.

Medical Benefits Chart

The Medical Benefits Chart on the following pages lists the services Freedom Blue PPO covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Freedom Blue PPO.
    - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018* Handbook. View it online at https://www.medicare.gov or ask for 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.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment may apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

	In-Network	Out-of-Network
Plan Deductible	None	
Plan Coinsurance	0% Coinsurance	10% Coinsurance
In Network Out-of-Pocket Maximum	$500	
Combined Out-of-Pocket Maximum	$750	

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. *A physician or specialist office copayment or coinsurance may apply for any non-preventive services rendered at time of visit.*
Ambulance services* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.	**Network:** $100 copay per one way trip for emergency and non-emergency ambulance services **Out-of-Network:** Emergency - $100 copay per one way trip for emergency ambulance services Non-Emergency – 10% of the total cost

Services that are covered for you	What you must pay when you get these services
• Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. To meet this definition, the member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the member is bed-confined, and it is documented that the member's condition is such that other methods of transportation are contraindicated; or, if the member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Prior Authorization Requirements All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member's non-emergent ambulance provider is responsible for obtaining prior authorization. Any non-emergency transportation services not prior authorized will not be covered.	*Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Non-emergency ambulance services require a Physician Certification Statement (PCS).*
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
to be covered for annual wellness visits after you've had Part B for 12 months.	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 12 months	**In and out-of-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost-sharing. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**Network:** $0 copay per service **Out-of-Network:** 10% of the total cost per service

Services that are covered for you	What you must pay when you get these services
 **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
 **Cardiovascular disease testing** Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In and out-of-network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. *Diagnostic testing will be subject to diagnostic cost-sharing if applicable.* *A physician or specialist office copayment may apply for any non-preventive services rendered at time of visit.*
 **Cervical and vaginal cancer screening** Covered services include: • For all women: Pap tests and pelvic exams are covered once every 12 months	**In and out-of-network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation.	**Network:** $20 copay for each Medicare-covered visit **Out-of-Network:** 10% of the total cost per Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**In and out-of-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. *If the screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and outpatient surgery cost sharing may apply.* *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Services that are covered for you	What you must pay when you get these services
levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	*A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
 **Diabetes self-management training, diabetic services and supplies*** For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests are covered 2 times per calendar year.	**Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% of the total cost for diabetic supplies and therapeutic shoes **Out-of-Network:** 50% of the total cost for diabetes Self-Monitoring Training and diabetic supplies and therapeutic shoes *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
• You must obtain diabetic testing supplies from Durable Medical Equipment (DME) suppliers. Diabetic testing supplies may be covered only if they are purchased at an approved retail pharmacy, call Customer Service for details. • Certain DME providers in the Freedom Blue PPO network have agreed to provide blood glucose monitors free of charge. Call Customer Service for details.	
Durable medical equipment and related supplies* (For a definition of "durable medical equipment," see Chapter 12 of your *Evidence of Coverage* booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.highmarkblueshield.com/medicare. Reimbursement for oxygen services includes payment for equipment rental, oxygen contents, and all accessories and supplies as necessary. Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.	**Network:** **Durable Medical Equipment:** 0% of the total cost for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 0% of the total cost for oxygen and oxygen related equipment **Out-of-Network:** **Durable Medical Equipment:** 50% of the total cost for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 50% of the total cost for oxygen and oxygen related equipment

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency care is covered worldwide.***	**In and out-of-network (including worldwide):** $65 copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for up to 48 hours for observation or rapid treatment as these are not considered hospital admissions. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
 **Health and wellness education programs** Tivity, Inc. SilverSneakers® Fitness program is the nation's leading wellness program designed exclusively for Medicare beneficiaries. Eligible members receive a fitness membership with access to all basic amenities plus fitness classes including the signature SilverSneakers classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination. SilverSneakers also offers FLEX™ classes including tai chi, yoga and dance in neighborhood locations such as medical campuses, older-adult living communities and parks. SilverSneakers Steps®, which includes various kits for members to use at home or when they travel, is an available alternative for members who can't get to a SilverSneakers fitness location.	**Network:** There is no charge for the SilverSneakers Fitness program and classes. **Out-of-Network:** Because of the unique nature of health and wellness programs, the availability of comparable, equivalent programs may be limited. Programs that qualify for benefit coverage are subject to a 50% coinsurance after satisfying a $500 deductible.

Services that are covered for you	What you must pay when you get these services
For more information, to find SilverSneakers fitness locations and FLEX classes, or to get started with SilverSneakers Steps, eligible members should visit silversneakers.com or call 1-888-423-4632 (TTY: 711), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. *Health and wellness education program coinsurances are not subject to the out-of-pocket maximum.*	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Covered services include: • Diagnostic hearing exams • Annual routine hearing exam • Hearing aid benefit every 3 calendar year(s) (benefit maximum is for either network or out-of-network services) *Plan deductible, if applicable, applies to out-of-network Medicare-covered hearing services.* *Routine hearing exams and hearing aids are not subject to plan deductible or the out-of-pocket maximum.*	**Network:** $20 copay for each Medicare-covered diagnostic hearing exam. $20 copay per annual routine hearing exam **Out-of-Network:** 10% per Medicare-covered diagnostic hearing exam 10% of the total cost per annual routine hearing exam You are covered up to $500 for hearing aids every 3 calendar year(s).
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover:	**In and out-of-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
• Up to three screening exams during a pregnancy	
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**Network:** $0 copay per visit **Out-of-Network:** 10% of the total cost per visit
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Freedom Blue PPO. **Network:** $10 copay for a one time only hospice consultation with a primary care physician **Out-of-network:** 10% of the total cost for a one time only hospice consultation with a primary care physician

Services that are covered for you	What you must pay when you get these services
• Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by Freedom Blue PPO but are not covered by Medicare Part A or B: Freedom Blue PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information,	

Services that are covered for you	What you must pay when you get these services
please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice) of the Evidence of Coverage booklet.* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
 **Immunizations** Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. Immunizations for the purpose of travel are not covered.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets	**Network:** 0% of the total cost per admission **Out-of-Network:** 10% of the total cost per admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
• Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside of the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Freedom Blue PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.	

Services that are covered for you	What you must pay when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care* • Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**Network:** 0% of the total cost per admission **Out-of-Network:** 10% of the total cost per admission
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay.	**Network:** $10 copay per primary care office visit $20 copay per specialist office visit $0 copay per radiation therapy visit

Services that are covered for you	What you must pay when you get these services
However, in some cases, we will cover certain services you receive while you are in the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	0% of the total cost for Medicare-covered lab services, diagnostic procedures and tests, X-rays, and diagnostic radiology services 0% of the total cost for durable medical equipment 0% of the total cost for oxygen and oxygen related equipment $20 copay for rehabilitation therapy **Out-of-Network:** 10% of the total cost per primary care office visit 10% of the total cost per specialist office visit 10% of the total cost for each Medicare-covered diagnostic procedures, tests and lab services, advanced imaging services, therapeutic radiology services, outpatient x-ray, and diagnostic radiology services 10% of the total cost per rehabilitation therapy 50% of the total cost for durable medical equipment 50% of the total cost for oxygen and oxygen related equipment
 **Medical nutrition therapy** This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive	**In and out-of-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	*A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
 **Medicare Diabetes Prevention Program (MDPP)** MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan	Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, toxoids, pathology drugs, laboratory drugs, contrast materials, and miscellaneous drugs and solutions. **Network:** You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®,) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	10% of the total cost for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs
 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
Please note: *Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig and Nutri-System) are not eligible.*	
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Advanced imaging services (such as CT Scans and MRIs) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Other outpatient diagnostic tests Either the freestanding or outpatient facility lab copayment may apply in a physician's office setting. Discuss with your physician about the designated site of service to identify the appropriate copayment.	**Network:** 0% of the total cost for Medicare-covered lab services, diagnostic procedures and tests, X-rays, and diagnostic radiology services including those performed in a freestanding lab, physicians office, or outpatient hospital facility 0% of the total cost for advanced imaging services $0 copay for therapeutic radiology services. There is no coinsurance, copayment, or deductible for outpatient blood. *Separate office visit cost sharing may apply.* **Out-of-Network:** 10% of the total cost for each Medicare-covered diagnostic procedures, tests and lab services, advanced imaging services, therapeutic radiology services, outpatient x-ray, outpatient blood, and diagnostic radiology services
Outpatient hospital services * We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:	**Network:** $65 copay for emergency services. 0% of the total cost per visit, per provider, per day for surgery performed in an outpatient hospital setting There is no coinsurance, copayment, or deductible for partial hospitalization.

Services that are covered for you	What you must pay when you get these services
• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$20 copay for each individual or group therapy visit for other mental health care services 0% of the total cost for Medicare-covered lab services, diagnostic procedures and tests, X-rays, and diagnostic radiology services 0% of the total cost for advanced imaging services You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs. **Out-of-Network:** 10% of the total cost for all services (except DME).
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician	**Network:** $20 copay for each individual or group therapy visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	10% of the total cost for each individual or group therapy visit.
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**Network:** $20 copay per therapy, per visit **Out-of-Network:** 10% of the total cost per therapy, per visit
Outpatient substance abuse services* Individual and group therapy visits on an outpatient basis for substance abuse.	**Network:** $20 copay per individual or group visit **Out-of-Network:** 10% of the total cost per individual or group visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	**Network:** 0% of the total cost per service, per day, per provider **Out-of-Network:** 10% of the total cost per service, per day, per provider
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community	**Network:** There is no coinsurance, copayment, or deductible.

Services that are covered for you	What you must pay when you get these services
mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**Out-of-Network:** 10% of the total cost
Physician/Practitioner services, including doctor's office visits* Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment. • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Second opinion prior to surgery • Non-routine dental care (covered 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) *Physician office visit copays are NOT applied to the in-network maximum out-of-pocket but do apply to the combined out-of-pocket maximum*	**Network:** $10 copay per primary care office visit $20 copay per specialist office visit 0% of the total cost per service, per day, per provider for each Medicare-covered ambulatory surgical center and/or outpatient hospital facility visit **Out-of-Network:** 10% of the total cost per primary care office visit 10% of the total cost per specialist office visit 10% of the total cost for services at an ambulatory surgical center and/or outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs *Routine podiatry visits are not subject to the out-of-pocket maximum.*	**Network:** $20 copay for each Medicare-covered visit **Out-of-Network:** 10% of the total cost for Medicare-covered services
 **Prostate cancer screening exams** For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In and out-of-network:** There is no coinsurance, copayment, or deductible for an annual PSA test. *Diagnostic testing will be subject to diagnostic cost-sharing.* *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	**Network:** 0% of the total cost for Medicare-covered items **Out-of-Network:** 50% of the total cost for Medicare-covered items

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**Network:** $0 copay per visit **Out-of-Network:** 10% of the total cost per visit
 **Screening and counseling to reduce alcohol misuse** We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
 **Screening for lung cancer with low dose computed tomography (LDCT)** For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Services to treat kidney disease and conditions Covered services include:	**Network:** $0 copay for kidney disease education services $0 copay for renal dialysis

Services that are covered for you	What you must pay when you get these services
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."	**Out-of-Network:** 10% of the total cost for renal dialysis
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") 100 days covered for each benefit period. Covered services include but are not limited to:	**Network:** 0% of the total cost per admission for days 1-100 A benefit period starts the day you are admitted at a Medicare-certified hospital or skilled nursing facility. It ends when you haven't been an inpatient at any hospital or SNF for 60 days

Services that are covered for you	What you must pay when you get these services
• Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Out-of-Network:** 10% of the total cost per admission for days 1-100

Services that are covered for you	What you must pay when you get these services
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *A physician or specialist office cost-sharing may apply for any non-preventive services rendered at time of visit.*
Telemedicine PCP visits for Post-Discharge Medication Reconciliation: Provides access to in-network follow-up visits via web and phone-based technologies if offered by your primary care physician for Medication Reconciliation Post-Discharge only.	**Network:** $10 copay per visit **Out-of-Network:** Not covered
Transportation* Plan provides a benefit for up-to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits; appointments for dental, vision, hearing, and behavioral health services; and visits to pharmacies to pick up prescription drugs within a 50 mile limit. Destination must always be plan-approved. Special circumstances may be accommodated at discretion of the plan. Mode of transportation could include van, medical transport, wheelchair van, or car at the	**Network:** $10 copay per one-way trip **Out-of-Network:** 50% of the total cost per one-way trip

Services that are covered for you	What you must pay when you get these services
discretion of the plan. If you pay out of pocket for these modes of transportation, reimbursement may be provided in special circumstances at the discretion of the plan; however, personal vehicle expenses will not be considered for reimbursement. Plan authorization and scheduling rules apply. Any routine transportation services not scheduled through plan or prior-authorized will not be covered. To obtain prior authorization and schedule a pickup, please call us **at least 48 hours in advance**. Contact Customer Service at the phone number on the back of your ID card, 8:00 a.m. - 5:00 p.m. Eastern Time Monday through Friday, excluding holidays. TTY users should call 711 National Relay Service.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Urgently needed services are covered worldwide.**	**In and out-of-network (including worldwide):** $40 copay per visit *Not waived if admitted.*
Vision care Covered services include:	**Network:** $20 copay per Medicare-covered eye exam **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) A $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	10% for Medicare-covered eye exams
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.	**In and out-of-network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. *A physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	

Part D Prescription Drugs Chart

Please note: Because your prescription coverage is better than the CMS Defined Standard Part D benefit, some drug coverage is provided through a Prescription Drug Coverage Gap Health Care Product, which is separate from your Freedom Blue PPO coverage.

The Deductible Stage

There is no deductible for Freedom Blue PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See below for information about your coverage in the Initial Coverage Stage.

The Initial Coverage Stage

A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (up to a 31-day supply)	Mail-order cost-sharing (up to a 31-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 of the *Evidence of Coverage* for details) (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$12 copay	$24 copay	$12 copay	Applicable network cost-sharing plus the difference between the out-of-network price and the network pharmacy price.
Cost-Sharing Tier 2 (Generic)	$12 copay	$24 copay	$12 copay	Applicable network cost-sharing plus the difference between the out-of-network price and the network pharmacy price.
Cost-Sharing Tier 3 (Preferred Brand)	$20 copay	$40 copay	$20 copay	Applicable network cost-sharing plus the difference between the out-of-network price and the network pharmacy price.
Cost-Sharing Tier 4 (Non-Preferred Drug)	$50 copay	$100 copay	$50 copay	Applicable network cost-sharing plus the difference between the out-of-network price and the network pharmacy price.
Cost-Sharing Tier 5 (Specialty)	$50 copay	$50 copay	$50 copay	Applicable network cost-sharing plus the difference between the out-of-network price and the network pharmacy price.

A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4 of your *Evidence of Coverage* booklet.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard retail cost-sharing (in-network) (up to a 90-day supply)	**Mail-order cost-sharing** (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$36 copay	$24 copay
Cost-Sharing Tier 2 (Generic)	$36 copay	$24 copay
Cost-Sharing Tier 3 (Preferred Brand)	$60 copay	$40 copay
Cost-Sharing Tier 4 (Non-Preferred Drug)	$150 copay	$100 copay
Cost-Sharing Tier 5 (Specialty)	*A long-term supply is not available for drugs in Specialty Tier 5*	*A long-term supply is not available for drugs in Specialty Tier 5*

The Coverage Gap Stage

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,000

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs, refer to Chapter 6, Section 6.2 in the *Evidence of Coverage* booklet for more information. When you reach an out-of-pocket limit of $5,000, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Coverage Gap

After your total yearly drug costs reach $3,750, you pay:

Tier 1: Preferred Generic

- $12 copay for a one-month (31-day) supply of drugs in this tier.
- $24 copay for a three-month (90-day) supply of drugs through the plan's mail order service in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier 2: Generic

- $12 copay for a one-month (31-day) supply of drugs in this tier.
- $24 copay for a three-month (90-day) supply of drugs through the plan's mail order service in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier 3: Preferred Brand

- $20 copay for a one-month (31-day) supply of drugs in this tier.
- $40 copay for a three-month (90-day) supply of drugs through the plan's mail order service in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier 4: Non-Preferred Drug

- $50 copay for a one-month (31-day) supply of drugs in this tier.
- $100 copay for a three-month (90-day) supply of drugs through the plan's mail order service in this tier. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier 5: Specialty

- $50 copay for a one-month (31-day) supply of drugs in this tier.
- *A long-term supply is not available for drugs in Specialty Tier 5*

The Catastrophic Coverage Stage

Once in the Catastrophic Coverage Stage, you stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:

- –*either* – Coinsurance of 5% of the cost of the drug
- –*or* – $3.35 for a generic drug or a drug that is treated like a generic and $8.35 for all other drugs.

- **Our plan pays the rest** of the cost.

Important Information about Certain Medicare Excluded Prescription Drugs

The following is a list of Medicare Part D excluded drugs covered under your plan.

Drug Name	Tier Status	Requirements/Limits
Caverject Vial (ea) 20 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Caverject Vial (ea) 40 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Caverject Kit 20 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Cialis Tablet 2.5 mg	Enhanced	QL (2 EA per 1 day), *, +
Cialis Tablet 5 mg	Enhanced	QL (1 EA per 1 day), *, +
Cialis Tablet 10 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Cialis Tablet 20 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Edex Kit 10 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Edex Kit 20 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Edex Kit 40 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Folic Acid Tablet 1 mg	Enhanced	*, +
Levitra Tablet 2.5 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Levitra Tablet 5 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Levitra Tablet 10 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Levitra Tablet 20 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 125 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 250 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 500 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 1000 mcg	Enhanced	QL (0.2 EA per 1 day), *, +
Quazepam Tablet 15 mg	Enhanced	*, +
Staxyn Tablet, Disintegrating 10 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg	Enhanced	*, +
Stendra Tablet 100 mg	Enhanced	*, +
Stendra Tablet 200 mg	Enhanced	*, +
Viagra Tablet 25 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Viagra Tablet 50 mg	Enhanced	QL (0.2 EA per 1 day), *, +
Viagra Tablet 100 mg	Enhanced	QL (0.2 EA per 1 day), *, +

+ - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you quality for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

NOTE: The Enhanced Tier includes Medicare Part D excluded drugs covered under your plan.

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You can find information on what the symbols and abbreviations on this table mean by going to page 8 of the formulary.

Highmark Senior Health Company, Highmark Choice Company and Highmark Senior Solutions Company are Medicare Advantage plans with a Medicare contract. HM Health Insurance Company is a PDP plan with a Medicare contract. Enrollment in Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company and HM Health Insurance Company depends on contract renewal. Highmark Blue Shield, Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company, and HM Health Insurance Company are independent licensees of the Blue Cross and Blue Shield Association.

Freedom Blue PPO Customer Service

CALL	1-866-918-5285 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	www.highmarkblueshield.com/medicare

Highmark Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.