This is only a summary of your plan’s benefits. See your Evidence of Coverage for more detailed information.

### 2018 Benefit Summary

<table>
<thead>
<tr>
<th>Freedom Blue PPO</th>
<th>In Network</th>
<th>Out Of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td>10%</td>
</tr>
<tr>
<td><strong>In Network Member Out-of-Pocket Maximum</strong></td>
<td>$500</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Combined In and Out-of-Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)</strong></td>
<td>$750</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Physical Exam</strong></td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Screenings &amp; Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate &amp; Bone Mass Measurement)</strong></td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Doctor Office Visit</strong></td>
<td>$10 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$20 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>X-ray or Radiology</strong></td>
<td>$0 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td>$0 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$0 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Emergency Room Services (Worldwide Coverage)</strong></td>
<td>$65 cost sharing</td>
<td>$65 cost sharing same as in-network</td>
</tr>
<tr>
<td><strong>Urgently Needed Care</strong></td>
<td>$40 cost sharing</td>
<td>$40 cost sharing same as in-network</td>
</tr>
<tr>
<td><strong>Inpatient Hospital or Long-Term Acute Care Facility Stay</strong></td>
<td>$0 cost sharing per stay</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care (100 days per Medicare benefit period)</strong></td>
<td>$0 cost sharing per day</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Annual Routine Hearing Exam</strong></td>
<td>$20 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td><strong>Hearing Aids (covered every three years)</strong></td>
<td>$500 allowance</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health</strong></td>
<td>0% cost sharing for Medicare-covered home health services</td>
<td>10% coinsurance</td>
</tr>
</tbody>
</table>

1. You must continue to pay your Medicare Part B premium.
### The Pennsylvania State University

#### Freedom Blue PPO

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out Of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, Speech and Occupational Therapy (per visit/per day/per provider)</td>
<td>$20 cost sharing</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Part B Drugs</td>
<td>0% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Ambulance (Emergent Services per one way trip)</td>
<td>$100 cost sharing</td>
<td>$100 cost sharing</td>
</tr>
<tr>
<td>Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Oxygen/Oxygen Supplies</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)</td>
<td>$0 cost sharing per stay</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)</td>
<td>$20 cost sharing</td>
<td>10% coinsurance</td>
</tr>
</tbody>
</table>

### PART D DRUGS

You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.

<table>
<thead>
<tr>
<th>Initial Coverage</th>
<th>Deductible</th>
<th>Retail Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>Tier 1 (Preferred Generic) $12 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2 (Generic) $12 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3 (Preferred Brand) $20 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4 (Non-Preferred Brand) $50 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5 (Specialty) $50 copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order Cost Sharing</th>
<th>Tier</th>
<th>Up to 90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 (Preferred Generic)</td>
<td>$24 copay</td>
</tr>
</tbody>
</table>
### Catastrophic Coverage

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750.01 until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

### Tier 2 (Generic)
- Tier 2 (Generic) - $24 copay

### Tier 3 (Preferred Brand)
- Tier 3 (Preferred Brand) - $40 copay

### Tier 4 (Non-Preferred Brand)
- Tier 4 (Non-Preferred Brand) - $100 copay

### Tier 5 (Specialty)
- Tier 5 (Specialty) - Not Available

### Catastrophic Coverage Description:
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $5,000.01, you pay the greater of: 5% of the cost, or a $3.35 copay for generics and a $8.35 copay for all other drugs.

### Mail Order Cost Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Up to 90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$24 copay</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
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<td>$20 copay</td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Brand)</td>
<td>$100 copay</td>
</tr>
</tbody>
</table>

### Retail Cost Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>Up to 31 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$12 copay</td>
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<tr>
<td>Tier 2 (Generic)</td>
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</tr>
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</tr>
<tr>
<td>Tier 5 (Specialty)</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Highmark Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.
Highmark Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).
请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): 18FB8428

EGHP_17_0998