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

2020 Benefit Summary

The Pennsylvania State University	Freedom Blue PPO	
	In Network	Out Of Network
Deductible	$0	
In Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)	$500	N/A
Combined In and Out-of-Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)	$750	
Annual Physical Exam	Covered in Full	Covered in Full
Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
Doctor Office Visit	$10 copay	$10 copay
Specialist Office Visit	$20 copay	$20 copay
Advanced Imaging (Examples: CT Scans, MRI)	$0 copay	$0 copay
Standard Imaging (Examples: X-Ray, Mammogram)	$0 copay	$0 copay
Diagnostic Testing (Example: Blood Work)	$0 copay	$0 copay
Outpatient Surgery	$0 copay	$0 copay
Emergency Room Services (Worldwide Coverage)	$65 copay	$65 copay
Urgently Needed Care	$40 copay	$40 copay
Inpatient Hospital or Long-Term Acute Care Facility Stay	$0 copay per admission	$0 copay per admission
Skilled Nursing Facility Care (100 days per Medicare benefit period)	$0 copay per day per admission	$0 copay per day per admission
Annual Routine Hearing Exam	$20 copay	$20 copay

[1] You must continue to pay your Medicare Part B premium.

The Pennsylvania State University	Freedom Blue PPO	
	In Network	Out Of Network
Hearing Aids (In-network covered every year)	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing	$500 allowance for hearing aids every 3 years from any other provider
Home Health	0% copay for Medicare-covered home health services	0% copay for Medicare-covered home health services
Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$20 copay	$20 copay
Renal Dialysis	$0 copay	10% coinsurance
Part B Drugs	0% coinsurance	0% coinsurance
Ambulance (Emergent Services per one way trip)	$100 copay	$100 copay
Ambulance (Non-Emergent Services per one way trip)	$100 copay	10% coinsurance
Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)	0% coinsurance	10% coinsurance
Oxygen/Oxygen Supplies	0% coinsurance	10% coinsurance
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	$0 copay per admission	$0 copay per admission
Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$20 copay	$20 copay

PART D DRUGS

You pay the following until your total yearly drug costs reach $4,020.01. Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.

Deductible	$0

		Tier	Up to 31 Day Supply
Initial Coverage Period	Retail Cost Sharing	Tier 1 (Preferred Generic)	$12 copay
		Tier 2 (Generic)	$12 copay
		Tier 3 (Preferred Brand)	$20 copay
		Tier 4 (Non-Preferred Drug)	$50 copay
		Tier 5 (Specialty)	$50 copay
		Tier	Up to 90 Day Supply
	Mail Order Cost Sharing	Tier 1 (Preferred Generic)	$24 copay
		Tier 2 (Generic)	$24 copay
		Tier 3 (Preferred Brand)	$40 copay
		Tier 4 (Non-Preferred Drug)	$100 copay
		Tier 5 (Specialty)	Not Available

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020.01 until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

		Tier	Up to 31 Day Supply
Coverage Gap	Retail Cost Sharing	Tier 1 (Preferred Generic)	$12 copay
		Tier 2 (Generic)	$12 copay
		Tier 3 (Preferred Brand)	$20 copay
		Tier 4 (Non-Preferred Drug)	$50 copay
		Tier 5 (Specialty)	$50 copay
		Tier	Up to 90 Day Supply
	Mail Order Cost Sharing	Tier 1 (Preferred Generic)	$24 copay
		Tier 2 (Generic)	$24 copay
		Tier 3 (Preferred Brand)	$40 copay
		Tier 4 (Non-Preferred Drug)	$100 copay
		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 $6,350.01, you pay the greater of: 5% of the cost, or a $3.60 copay for generics and a $8.95 copay for all other drugs.	
Catastrophic Coverage	Greater of: 5% or $3.60 Generic/Preferred Multi-Source or $8.95 for all others.

Highmark Senior Health Company and Highmark Senior Solutions Company are PPO plans with a Medicare contract. Enrollment in Highmark Senior Health Company and Highmark Senior Solutions Company depends on contract renewal.

Highmark Blue Shield, Highmark Senior Health Company, and Highmark Senior Solutions 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, pharmacy network and provider network 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): **20FB178428**

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