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

Annual Notice of Changes for 2020

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 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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

- Are your doctors, including specialists you see regularly, 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 2.2 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, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Freedom Blue PPO through your former employer/trust fund.
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

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 Qualifying Health Coverage (QHC)** 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 2020

The table below compares the 2019 costs and 2020 costs for Freedom Blue PPO in several important areas. **Please note this is only a summary of changes**. You may call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (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 copay per visit Specialist visits: **Network:** $20 copay per visit **Out-of-Network:** $20 copay per visit	Primary care visits: **Network:** $10 copay per visit **Out-of-Network:** $10 copay per visit Specialist visits: **Network:** $20 copay per visit **Out-of-Network:** $20 copay per 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:** 0% of the total cost	**Network:** 0% of the total cost **Out-of-Network:** 0% of the total cost
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage:	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage:

Cost	2019 (this year)	2020 (next year)
	• **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	• **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 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	2019 (this year)	2020 (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 will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles, if	$750	$750 Once you have paid $750 out-of-pocket for covered Part A and Part B services,

Cost	2019 (this year)	2020 (next year)
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.		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 medicare.highmark.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2020 *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, we must 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 39 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 medicare.highmark.com. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2020 *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.

	2019 (this year)	2020 (next year)
Screening for Lung Cancer	Eligible members are people aged 55-77	Eligible members are people aged 55-80
Telehealth	**Network:** You pay a $10 copay per visit. **Out-of-Network:** You have a $500 deductible then you pay a 50% coinsurance of the total cost per visit.	**Network:** You pay a $10 copay for a PCP visit and a $20 copay for a specialist visit. **Out-of-Network:** Telehealth service is not covered except for the following: medication reconciliation clinic counseling (chronic disease and medication management) and nutritional counseling. You pay a $10 copay for a PCP visit and a $20 copay for a specialist visit. See list of additional covered conditions and services in the attached *Medical Benefits Chart*.

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 provided electronically.

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 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 2019, you may need to ask for a new formulary exception for the same drug in 2020.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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 December 15, 2019, please call Customer Service and ask for the "LIS Rider." Phone numbers for Customer Service are in Section 6.1 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 enclosed *Part D Prescription Drugs* appendix 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 *Evidence of Coverage* and the enclosed *Part D Prescription Drugs* appendix. You may call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (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.

Stage	2019 (this year)	2020 (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.** 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 the enclosed *Part D Prescription Drugs* appendix. **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.**	Your cost for a one-month supply filled at a network 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 $3,820, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network 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 $4,020, 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 enclosed *Part D Prescription Drug* appendix.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – 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 2020.

Section 2.2 – 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 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *– 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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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 6.1 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 3 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, 2020.

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 may be 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, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 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 5 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 6 Questions?

Section 6.1 – 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 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Freedom Blue PPO and the *Medical Benefits Chart* appendix. 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. You may call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at medicare.highmark.com. 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 6.2 – 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 2020*

You can read *Medicare & You 2020* 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 2020* 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 2020, 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%	10%
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. *Physician or specialist office cost-sharing may apply for any non-preventive services also 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:** $100 copay per one way trip for emergency ambulance services Non-Emergency – 10% of the total cost per one way trip

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. <u>Prior Authorization Requirements</u> 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).* Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.
Annual routine physical exam We cover one visit per calendar year. The exam services include: • Visual inspection of the body • Tapping specific areas of the body and listening to sounds • Checking vital signs and measuring height/weight	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual routine physical exam. *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
 **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 calendar year. **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 to be covered for annual wellness visits after you've had Part B for 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Bathroom Safety Devices* This benefit is part of your Durable Medicare Equipment benefit. (For a definition of "durable medical equipment," see Chapter 12 of the *Evidence of Coverage*.) Covered services limited to: • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years	**Network:** 0% of the total cost **Out-of-Network:** 10% of the total cost
 **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. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
 **Breast cancer screening (mammograms)** Covered services include:	**In and Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• One baseline mammogram between the ages of 35 and 39 • One screening mammogram every calendar year for women age 40 and older • Clinical breast exams once every calendar year	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. *Physician or specialist office cost-sharing may apply for any non-preventive services also 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:** $0 copay per service
 **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 healthy.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. *Physician or specialist office cost-sharing may apply for any non-preventive services also 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.

Services that are covered for you	What you must pay when you get these services
	Physician or specialist office cost-sharing may apply for any non-preventive services also 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 calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Diagnostic testing will be subject to diagnostic cost-sharing if applicable. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation.	**Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening CT Colonography for people ages 50-75 years old once every five years One of the following every calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	**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. *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
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	
Depression screening We cover one screening for depression per calendar year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. *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 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *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
 **Diabetes self-management training, diabetic services and supplies***	**Network:**
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. • You must obtain diabetic testing supplies from Durable Medical Equipment (DME) suppliers. Diabetic testing supplies may be covered if 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.	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:** 10% of the total cost for diabetic supplies and therapeutic shoes *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
Durable medical equipment and related supplies* (For a definition of "durable medical equipment," see Chapter 12 of the *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 medicare.highmark.com. 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:** 10% of the total cost for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 10% of the total cost for oxygen and oxygen related equipment
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	**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 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

Services that are covered for you	What you must pay when you get these services
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.***	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** Highmark's health and wellness education program provides access to network gyms and fitness classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination through the Tivity, Inc. SilverSneakers® Fitness program. Eligible members receive a membership at network fitness facilities with access to all basic amenities plus SilverSneakers® fitness classes. SilverSneakers FLEX™ classes (which include tai chi, yoga and dance) are 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 network fitness location. 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 National Relay Service), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.	**Network:** There is no charge for the fitness program. **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
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: • 1 routine hearing exam per calendar year Hearing Aids: Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Call **1-855-544-7171** (for TTY, dial 711) Monday through Friday, 9:00 a.m. to 9:00 p.m., Eastern Time to schedule an appointment. Hearing aid purchases <u>through a TruHearing provider</u> includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3 year extended warranty • 48 batteries per aid for non-rechargeable models Benefit <u>does not</u> include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Extra batteries	**Network:** $20 copay for each Medicare-covered diagnostic hearing exam. $20 copay per annual routine hearing exam $499 per aid for TruHearing Advanced Aids $799 per aid for TruHearing Premium Aids **Out-of-Network:** $20 per Medicare-covered hearing exam $20 copay per annual routine hearing exam $500 allowance for hearing aids every 3 calendar years from any other provider or TruHearing.

Services that are covered for you	What you must pay when you get these services
• Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. *Plan deductible, if applicable, applies to out-of-network Medicare-covered hearing services.* *Routine hearing exams and hearing aid copayments are not subject to plan deductible or the out-of-pocket maximum.*	
 **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: • Up to three screening exams during a pregnancy	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
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:	**Network:** $0 copay per visit **Out-of-Network:** 0% of the total cost per visit

Services that are covered for you	What you must pay when you get these services
• 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	
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 • Home care <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> 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. <u>For services that are covered by Medicare Part A or B and are not related to your terminal</u>	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 copay 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
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, 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.	

Services that are covered for you	What you must pay when you get these services
 **Immunizations** Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • 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. *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 • 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	**Network:** 0% of the total cost per admission **Out-of-Network:** 0% 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
• 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 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. • 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	

Services that are covered for you	What you must pay when you get these services
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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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:** 0% 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. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests)	**Network:** $10 copay per primary care office visit $20 copay per specialist office visit $0 copay per radiation therapy visit 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 per therapy type, per provider, per visit for rehabilitation services

Services that are covered for you	What you must pay when you get these services
• 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	**Out-of-Network:** $10 copay per primary care office visit $20 copay per specialist office visit 0% of the total cost per radiation therapy visit 0% of the total cost for Medicare-covered diagnostic procedures, tests and lab services, advanced imaging services, outpatient x-ray, and diagnostic radiology services $20 copay per therapy type, per provider, per visit for rehabilitation services 10% of the total cost for DME, prosthetics and orthotics 10% 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 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	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. *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
must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
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. Part B drugs may be subject to step therapy requirements. 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 • 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	**Network:** 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. You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs.

Services that are covered for you	What you must pay when you get these services
• 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 The following link will take you to a list of Part B Drugs that may be subject to step therapy: medicare.highmark.com 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.	
 **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. ***Please note:*** *Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig and Nutri-System) are not eligible.*	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. *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
Opioid Treatment Program Services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	**Network:** A $20 copay per individual or group visit **Out-of-Network:** A $20 copay per individual or group visit
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	**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/diagnostic radiology tests $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:** 0% of the total cost for Medicare-covered diagnostic procedures, tests and lab services, advanced imaging services, outpatient x-ray, outpatient blood, and diagnostic radiology services

Services that are covered for you	What you must pay when you get these services
Either the freestanding or outpatient facility lab copayment may apply in a physician's office setting. If your physician sends your lab or diagnostic test to another facility for analysis, you may be billed separately by the performing provider.	
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	**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 **Out-of-Network:** $65 copay for emergency services 0% of the total cost for services at an outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services*	**Network:**
We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.	$65 copay for emergency services
Covered services include, but are not limited to: • 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	0% of the total cost per visit, per provider, per day for surgery performed in an ambulatory surgical center or outpatient hospital setting There is no coinsurance, copayment, or deductible for partial hospitalization. $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/diagnostic radiology services 0% of the total cost for Medicare-covered durable medical equipment (DME) items You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs.
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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call	**Out-of-Network:** $65 copay for emergency services 0% of the total cost for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% of the total cost for Medicare-covered diagnostic procedures, tests and lab services, outpatient x-ray,and outpatient blood 0% of the total cost for advanced imaging services/diagnostic radiology services $20 copay for each individual or group therapy visit for mental health services 10% of the total cost for Medicare-covered durable medical equipment (DME) items

Services that are covered for you	What you must pay when you get these services
1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You are covered at 100% for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs.
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 assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**Network:** $20 copay for each individual or group therapy visit **Out-of-Network:** $20 copay 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 provider, per visit **Out-of-Network:** $20 copay per therapy type, per provider, 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:** $20 copay 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	**Network:** 0% of the total cost per service, per day, per provider **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
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."	0% 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 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.	**Network:** There is no coinsurance, copayment, or deductible. **Out-of-Network:** 0% 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 specialist, if your doctor orders it to see if you need medical treatment	**Network:** $10 copay per primary care office visit $20 copay per specialist office visit $20 copay per retail clinic 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 copay per primary care office visit $20 copay per specialist office visit $20 copay per retail clinic visit 0% 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
• Certain telehealth services, including for: cough and sinus problems, back pain, bariatric surgery consults, diarrhea, eye irritation, cardiac conditions, chronic care management for CHF, COPD, diabetes, pulmonology conditions, endocrine system conditions, esophageal/ lung conditions, gastroenterological conditions, orthopedic, rheumatology conditions, wound and critical care, dermatology, rash (e.g. cold sores, shingles, poison ivy, scabies, insect bites and cellulitis), oncology and genetic counseling for patients identified with cancer/cancer risk, neurological conditions, urinary problems, urological conditions, vaginal discharge/ irritation consults, behavioral/ mental health services, medication reconciliation post-discharge, pharmacy clinic counseling (chronic disease and medication management) and nutritional counseling. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. • 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 • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	

Services that are covered for you	What you must pay when you get these services
• Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke • Brief virtual (for example, via telephone or video chat) 5-10 minute check-ins with your doctor—if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient • 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)	
Podiatry services Covered services include:	**Network:** $20 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
• 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	**Out-of-Network:** $20 copay for Medicare-covered services
 **Prostate cancer screening exams** For men age 50 and older, covered services include the following - once every calendar year: • 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. *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:** 10% of the total cost for Medicare-covered items
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:** 0% of the total cost per visit

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per calendar year 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. *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 calendar year. **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. *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	**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
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. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of visit.*
Services to treat kidney disease Covered services include: • 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)	**Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** 10% of the total cost for renal dialysis

Services that are covered for you	What you must pay when you get these services
• 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, "Medicare Part B prescription drugs."	
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: • 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.)	**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 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:** 0% 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
• 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	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *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
<u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> 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.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**Network:** $0 copay per visit **Out-of-Network:** 0% of the total cost per visit

Services that are covered for you	What you must pay when you get these services
Telehealth Provides access to in-network visits via web and phone-based technologies if offered by your PCP or Specialist. Coverage is limited to the following conditions: • cough and sinus problems, back pain, bariatric surgery consults, diarrhea, eye irritation, cardiac conditions, chronic care management for CHF, COPD, diabetes, pulmonology conditions, endocrine system conditions, esophageal/lung conditions, gastroenterological conditions, orthopedic, rheumatology conditions, wound and critical care • dermatology, rash (e.g. cold sores, shingles, poison ivy, scabies, insect bites and cellulitis) • oncology and genetic counseling for patients identified with cancer/cancer risk, neurological conditions • urinary problems and urological conditions, vaginal discharge/irritation • consults and behavioral/mental health services • medication reconciliation post-discharge, pharmacy clinic counseling (chronic disease and medication management) and nutritional counseling Any other conditions or services would not be covered. *Telehealth out-of-network services are not subject to the maximum out-of-pocket.*	**Network:** $10 copay per PCP visit and a $20 copay per specialist visit **Out-of-Network:** Only medication reconciliation post-discharge, pharmacy clinic counseling (chronic disease and medication management) and nutritional counseling are covered. $10 copay per primary care visit and a $20 copay per specialist visit All other conditions/services are <u>not</u> covered out-of-network.
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	**Network:** $10 copay per one-way trip **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
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. Mode of transportation could include van, medical transport, wheelchair van, or car at the 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 the 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. to 5:00 p.m. Eastern Time, Monday through Friday excluding holidays. TTY users should call 711 National Relay Service. *Transportation services are not subject to the maximum out-of-pocket.*	50% of the total cost per one way-trip Transportation services that are arranged for you for continued acute care after discharge from an emergency room does not apply towards the trip limit. This is limited to a one way trip to the home and any round-trip to a physician's office related to the emergency condition.
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.	**In and Out-of-Network (including worldwide):** $40 copay per visit *Not waived if admitted.*

Services that are covered for you	What you must pay when you get these services
Urgently needed services are covered worldwide.	
 **Vision care** Covered services include: • 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.	**Network:** $20 copay per Medicare-covered eye exam **Out-of-Network:** $20 copay per Medicare-covered eye exam

Services that are covered for you	What you must pay when you get these services
 **"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. **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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. *Physician or specialist office cost-sharing may apply for any non-preventive services also rendered at time of 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 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 $6,350

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 $6,350, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Coverage Gap

After your total yearly drug costs reach $4,020, 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 $6,350 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* – $3.60 for a generic drug or a drug that is treated like a generic and $8.95 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. The cost sharing for these drugs is Generic-Tier 2 and Brand-Tier 4 listed in your plan documents.

Drug Name	Requirements/Limits
Caverject Vial (ea) 20 mcg	QL (0.2 EA per 1 day), *, +
Caverject Vial (ea) 40 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 20 mcg	QL (0.2 EA per 1 day), *, +
Cialis Tablet 2.5 mg	QL (2 EA per 1 day), *, +
Cialis Tablet 5 mg	QL (1 EA per 1 day), *, +
Cialis Tablet 10 mg	QL (0.2 EA per 1 day), *, +
Cialis Tablet 20 mg	QL (0.2 EA per 1 day), *, +
Edex Kit 10 mcg	QL (0.2 EA per 1 day), *, +
Edex Kit 20 mcg	QL (0.2 EA per 1 day), *, +
Edex Kit 40 mcg	QL (0.2 EA per 1 day), *, +
Ergocal Ciferol 1.25 mg	*, +
Folic Acid Tablet 1 mg	*, +
Levitra Tablet 2.5 mg	QL (0.2 EA per 1 day), *, +
Levitra Tablet 5 mg	QL (0.2 EA per 1 day), *, +
Levitra Tablet 10 mg	QL (0.2 EA per 1 day), *, +
Levitra Tablet 20 mg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 125 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 250 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 500 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 1000 mcg	QL (0.2 EA per 1 day), *, +
Promethazine HCL/Codeine Syrup 6.25-10/5	*, +
Promethazine DM Syrup 6.25-15/5	*, +
Quazepam Tablet 15 mg	*, +
Staxyn Tablet, Disintegrating 10 mg	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg	*, +
Stendra Tablet 100 mg	*, +
Stendra Tablet 200 mg	*, +
Viagra Tablet 25 mg	QL (0.2 EA per 1 day), *, +
Viagra Tablet 50 mg	QL (0.2 EA per 1 day), *, +
Viagra Tablet 100 mg	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.

You can find information on what the symbols and abbreviations on this table mean by going to page 10 of the formulary.

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	medicare.highmark.com

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