Medicare Advantage
2025 Benefit Summary

Name: The Pennsylvania State University-0178428

	Freedom Blue PPO (PA) PPO	
Medical Benefits	**In-Network**	**Out-of-Network**
Deductible	$200 *	
Coinsurance (see specific benefits for cost sharing)	0%	0%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$500	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$500	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$10	$10
Office Visits - Specialist	$20	$20
Radiation Therapy	0%	0%
Emergency Room (waived if admitted within 3 days)	$100	
Urgent Care	$40	
Ambulance (Emergent)	$100	
Ambulance (Non-Emergent)	$100	10%
Routine Transportation Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	$10	50%
More than 20 Preventive Services	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	0%	0%
Observation Room/Outpatient Surgery (Hospital)	0%	0%
Outpatient Surgery (Ambulatory Center)	$0	$0
Home Health Care	0%	0%
Skilled Nursing Facility (100 days per benefit period)	0% per day 1-100	0% per day 1-100
Dialysis	$0	10%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	0%	0%
Mental Health (Outpatient)	$20	$20
Mental Health (Outpatient with Psychiatrist)	$20	$20
Alcohol Substance Abuse (Inpatient)	0%	0%
Alcohol Substance Abuse (Outpatient)	$20	$20

Laboratory and X-ray Services	In-Network	Out-of-Network
Laboratory Testing (Physician Office/Free Standing Lab)	0%	0%
Laboratory Testing (Outpatient Facility)	0%	0%
X-rays	0%	0%
Advanced Radiology (MRI, MRA, PET, and CT)	0%	0%
Rehabilitation Services	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$20	$20
Chiropractor Medicare Covered	$20	$20
Cardiac Rehab	$0	0%
Vision	**In-Network**	**Out-of-Network**
Medical Vision Exam	$20	$20
Routine Vision Exam (Offered through Davis Vision)	Not Covered	Not Covered
Annual allowance (lenses and frames) Offered through Davis Vision	Not Covered	Not Covered
Hearing	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$20	$20
Routine Hearing Exam (TruHearing)	$20	20
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid.	$500 allowance for hearing aids every 3 years
Dental	**In-Network**	**Out-of-Network**
Routine Dental	Not Covered	Not Covered
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**
Durable Medical Equipment	0%	10%
Prosthetics	0%	10%
Oxygen	0%	10%

Diabetic Supplies (Part B)	0%	0%
Fitness Program	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Covered	
Part B Drugs	**In-Network**	**Out-of-Network**
Immunosuppressive Drugs	0%	0%
Oral Chemotherapy Drugs	0%	0%
Physician Administered Injectables	0%	0%
Nebulizer Inhalation	0%	0%
Part B drugs (other)	0%	0%
Value Added Rider	**In-Network**	**Out-of-Network**
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 8 per calendar year.	Not Covered	Not Covered
Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 10 visits per calendar year.	Not Covered	Not Covered
Meal Plan - 2 meals per day up to 14 days upon discharge from an Inpatient Hospital or SNF stay	Not Covered	Not Applicable
Over the Counter Drug Allowance	Not Covered	Not Applicable
Prescription Drugs - Part D		
Prescription Deductible	Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	$2,000	
Formulary	Incentive	
Medicare Excluded Part D Prescription Drug Rider	Covered	
Retail Prescription Drugs		
Tier 1 (Preferred Generic)	$12	
Tier 2 (Non-Preferred Generic)	$12	
Tier 3 (Preferred Brand & Generic)	$35	
Tier 4 (Non-Preferred)	$65	
Tier 5 (Specialty)	0%	
Mail Order Prescription Drugs		
Tier 1 (Preferred Generic)	$24	
Tier 2 (Non-Preferred Generic)	$24	
Tier 3 (Preferred Brand & Generic)	$40	
Tier 4 (Non-Preferred)	$100	
Tier 5 (Specialty)	0%	
Retail and Mail Order Days Supply Limit	- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply -Insulin - $35 maximum copay for a one-month supply of covered insulin products	
Catastrophic Phase	After reaching the True Out of Pocket (TrOOP) costs, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	

* The deductible does not apply to the following services:
• Emergency and urgently needed care
• Health education and management programs (may have a separate deductible for OON)
• Insulin furnished through an item of durable medical equipment
• Medicare covered chiropractic services
• Medicare covered diabetes self-management training and fasting plasma glucose tests
• Medicare covered medical nutrition therapy and kidney disease education services
• Medicare covered preventive care, screening tests, and immunizations
• Medicare covered vision and hearing exams
• Psychiatric physician services
• Primary Care Physician (PCP) and Specialist physician office visits
• Routine vision and hearing services, if applicable

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

The Blue Shield(c) and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express Scripts® is a separate company. Other Pharmacies/Physicians/Providers are available in our network.

Out-of-network/non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物 计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号 码即可。说中文的工作人员可为您提供帮助。此项服务免 费。

For questions about this plan's benefits or costs, please call 1-866-456-7739 (TTY 711), Monday -Friday 8 am - 4:30 pm.

Please have this number ready when you call 25FB0178428

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