HIGHMARK®
SENIOR HEALTH COMPANY

Freedom Blue PPO sponsored by The Pennsylvania State University (Group # 0178428) offered by Highmark Senior Health Company

Annual Notice of Changes for 2025

You are currently enrolled as a member of Freedom Blue PPO. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs.***

This document tells about the changes to your plan. It also provides complete Medical and Prescription Benefit Charts. To get more information about benefits or rules please call Member Service to ask us to mail you an *Evidence of Coverage*.

- **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.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 Drug List to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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 don't join another plan by December 7, 2024, you will stay in Freedom Blue PPO through your former employer/trust fund.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Freedom Blue PPO.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member 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 call is free.
- This information is available in alternate formats such as large print and audio.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Freedom Blue PPO

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

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Freedom Blue PPO in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Deductible	$0 except for insulin furnished through an item of durable medical equipment.	$200 except for insulin furnished through an item of durable medical equipment.
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 **in-network** providers: $500 From **in-network and out-of-network** providers combined: $750	From **in-network** providers: $500 From **in-network and out-of-network** providers combined: $500
Doctor office visits	**Primary care visits:** **In-Network:** $10 copay per visit **Out-of-Network:** $10 copay per visit **Specialist visits:** **In-Network:** $20 copay per visit **Out-of-Network:** $20 copay per visit	**Primary care visits:** **In-Network:** $10 copay per visit **Out-of-Network:** $10 copay per visit **Specialist visits:** **In-Network:** $20 copay per visit **Out-of-Network:** $20 copay per visit
Inpatient hospital stays	**In-Network:** 0% of the total cost per admission **Out-of-Network:** 0% of the total cost per admission	**In-Network:** 0% of the total cost per admission **Out-of-Network:** 0% of the total cost per admission

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** $50 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • You may have cost sharing for excluded drugs that are covered under our enhanced drug benefit.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:**$12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $35 copay • **Drug Tier 4:** $65 copay You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** $65 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for excluded drugs that are covered under our enhanced drug benefit.

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. Please see Section 6 regarding "Extra Help" from Medicare.

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

Medicare requires all health plans to limit how much you pay out of pocket for 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	2024 (this year)	2025 (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 applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$750	$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 or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at medicare.highmark.com. You may also call Member Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the *2025 Provider/ Pharmacy Directory* (medicare.highmark.com)to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the *2025 Provider/ Pharmacy Directory* (medicare.highmark.com) to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Service so we may assist.

Blue Cross Blue Shield Association Network Sharing

Participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are available in 48 states and 2 territories. 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 may 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 Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

	2024 (this year)	2025 (next year)
Diabetic Supplies	**In-Network:**	**In-Network:**

	2024 (this year)	2025 (next year)
	Abbott and Lifescan glucometers, diabetic test strips, lancets, and an Abbott continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).	Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott and Dexcom continuous glucose monitoring devices are now available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).
Emergency Care	You pay a $65 copay.	You pay a $100 copay.
Health & Wellness	**In-Network:** Access to SilverSneakers - a program with network gyms and fitness classes. **Out-of-Network:** $500 deductible then paid at 50% coinsurance for approved programs	Your plan provides a subscription to a fitness and health platform that gives you extra options - including access to a nationwide network of gyms, fitness studios, and community centers. This benefit also includes unlimited access to a digital library of at-home workouts, wellness and more. You will receive 32 credits each month to use towards memberships/classes at these gyms and fitness facilities. Members must create an account online via mobile app or website and then select the fitness facility. You may also contact Member Service for assistance in creating an account. You will be responsible for all fees that exceed the monthly credit balance. Unused credits will not roll over to the following month. More information on how credits are used will be provided by January 2025.

Section 1.5 – 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", which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

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 you haven't received this insert by December 15, 2024, please call Member Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Stage	2024 (this year)	2025 (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, 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.	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 $35 per prescription. **Tier 4 Non-Preferred Drug:** You pay $65 per prescription.

Stage	2024 (this year)	2025 (next year)
Most adult Part D vaccines are covered at no cost to you.	You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay $50 per prescription. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay $65 per prescription. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at your attached *Prescription Drug Chart* and your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024	2025
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across

Description	2024	2025
		monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at 1-866-845-1803 (24 hours a day, 7 days a week) or visit Medicare.gov.
Member Service - Pharmacy	Not applicable	For pharmacy benefit questions or concerns, call: 1-866-675-8637 Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
Prior Authorization **(for in-network services)**	Authorization required for: • Partial Hospitalization • Outpatient Mental Health/Psychiatric services • Outpatient Substance Abuse/Opioid Treatment services • Outpatient Hospital Observation	Authorization requirement for services listed in 2024 column has been removed. Benefit categories that require authorization are marked with an asterisk (*) in the *Medical Benefits Chart*.

SECTION 3 Deciding Which Plan to Choose

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

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 31, you will automatically be enrolled in Freedom Blue PPO through your former employer/trust fund.

Section 3.2 – If you want to change plans

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

We hope to keep you as a member next year but if you want to change for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *– OR–* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5) or call Medicare (see Section 7.2).

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 Member Service if you need more information on how to do so.
    - *– OR –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 31.** The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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* document for a list of SHIP contact information by state.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office.

- **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.
- **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. To be eligible for the ADAP operating in your State, 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 or if you are currently enrolled how to continue receiving assistance, please see the *Agency Contact Information* appendix in the back of the *Evidence of Coverage* and call your state-specific program. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at the phone number on the back of your ID card or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Freedom Blue PPO

Questions? We're here to help. Please call Member Service at 1-866-918-5285. (TTY users should 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 2025 *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 2025. For details, look in the 2025 *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 Member 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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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, equipment, and Part B prescription drugs) *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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- 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.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

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 2025* handbook. View it online at 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 will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

Medical Benefits Chart - 0178428

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

✓ You will see this symbol next to a service that does not apply to the Out-of-Pocket Maximum.

* You will see this symbol next to a service that requires prior authorization.

	In-Network	Out-of-Network
Plan Deductible	$200	
Plan Coinsurance	See Benefit detail below for in-network coinsurance	See Benefit detail below for out-of-network coinsurance
In-Network Out-of-Pocket Maximum	$500	
Combined Out-of-Pocket Maximum	$500	

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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer;	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS	

Services that are covered for you	What you must pay when you get these services
required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, 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. If the covered ambulance services are not for an emergency situation, it should be 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 (requires a Physician Certification Statement (PCS)) 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.**	**In-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 10% coinsurance per one way trip for <u>non-emergency</u> ambulance services Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.

Services that are covered for you	What you must pay when you get these services
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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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 are limited to: • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years	**In-Network:** 0% coinsurance **Out-of-Network:** 10% coinsurance
 **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	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
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.	*Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 (includes 3D mammogram) • One screening mammogram every calendar year for women aged 40 and older (includes 3D mammogram) • Clinical breast exams once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing. *A physician or specialist copay 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.	**In-Network:** $0 copay per service **Out-of-Network:** 0% coinsurance 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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which Medicare Part B cost sharing may apply. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you may have additional

Services that are covered for you	What you must pay when you get these services
• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	cost sharing that applies to the type of service received. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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, specialist or additional medically necessary diagnostic services cost sharing may*

Services that are covered for you	What you must pay when you get these services
	apply for any non-preventive services rendered at the time of the 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **Diabetes self-management training, diabetic services and supplies*** For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	**In-Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% coinsurance for diabetic supplies and therapeutic shoes Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott and Dexcom continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process). **Out-of-Network:** 10% coinsurance for diabetic supplies and therapeutic shoes

Services that are covered for you	What you must pay when you get these services
• 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 Member Service for details. • Certain DME providers in the Freedom Blue PPO network have agreed to provide blood glucose monitors free of charge. Call Member Service for details. ***Prior authorization is required for certain items**	*Physician or specialist cost sharing may apply for any non-preventive services also rendered at time of visit.*
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage*.) 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.	**In-Network:** 0% coinsurance for Medicare-covered DME items Your cost sharing for Medicare-covered oxygen equipment coverage is 0% coinsurance, every month. After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 0% coinsurance for the oxygen contents. **Out-of-Network:** 10% coinsurance for Medicare-covered DME items Your cost sharing is 10% coinsurance for Medicare-covered oxygen and oxygen related equipment *DME items must be purchased from a Medicare participating provider.*

Services that are covered for you	What you must pay when you get these services
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. ***Prior authorization is required for certain items**	
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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency care is covered worldwide.***	**In and Out-of-Network (including worldwide):** $100 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 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.
Enhanced disease management **Onduo/VerilyMe Diabetes Management** is a virtual care program that helps individuals manage their diabetes. The Type 1 and Type 2 diabetes programs help guide individuals to eat healthier, be more active, and create other lifestyle changes. It includes diabetes testing supplies, app experiences, and support from personal coaches, clinicians and care specialists, including access to physicians through	There is no cost to eligible members.

Services that are covered for you	What you must pay when you get these services
telemedicine when needed. To be eligible, the member must have diabetes and own a smartphone (to use the app). Other inclusion/ exclusion criteria may apply. **Highmark Mental Well-Being by Spring Health** offers a mental and behavioral health care program with digital tools/programs, coaching, and in-person and virtual clinical support to help members address a broad spectrum of behavioral health needs. **CHF and COPD management powered by Vida** offers a solution to treat and manage members with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). This program is only available using digital or smartphone technology. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments.	
 **Health and wellness education programs** You have access to a nationwide network of gyms, local fitness studios, and community centers through FitOn Health. The number of credits you receive are set each month and do not rollover. Your FitOn account offers unlimited access to a digital library without using any of your 32 monthly credits. The digital library includes: • At-home fitness and wellness classes • Meditation classes • Nutrition and meal planning • Lifestyle advice • And much more	**In-Network and Out-of-Network:** You receive 32 credits per month; ✓ You pay 100% for visits exceeding your credit allowance.

Services that are covered for you	What you must pay when you get these services
To learn more about FitOn Health and to search for participating gyms and studios, visit www.fitonhealth.com/medicare. You can also find the credit cost per gym by visiting the FitOn Health website or by calling **1-855-946-4036** (TTY 711). Customer Service hours of operation are Monday through Friday, 8:00 a.m. to 9:00 p.m. If the cost for gym memberships exceeds your 32 monthly credit allowance, you will be responsible for purchasing additional credits to cover the cost difference at that facility. ✓*Any amount paid for health and wellness services that exceed your monthly credit allowance are not subject to the maximum out-of-pocket.*	
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** (TTY users, 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:	**In-Network:** $20 copay per Medicare-covered 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 copay per Medicare-covered hearing exam ✓ $20 copay per annual routine hearing exam **In and Out-of-Network:** ✓ $500 allowance for any other hearing aids every 3 calendar years thru TruHearing or any other provider.

Services that are covered for you	What you must pay when you get these services
• first year of hearing aid purchase provider visits • 60-day trial period • 3 year extended warranty • 80 batteries per aid for non-rechargeable models Benefit <u>does not</u> include or cover any of the following: • Additional provider visits • Ear molds • Hearing aid accessories • Extra batteries • 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 copays are not subject to plan deductible, if applicable, 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 calendar year For women who are pregnant, we cover:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
• Up to three screening exams during a pregnancy	
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit Please reference *Durable medical equipment (DME) and related supplies* above for medical equipment and supplies.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to:	**In-Network:** 0% coinsurance per visit **Out-of-network:** 0% coinsurance per visit Medicare Part B drugs that are billed separately may be billed under the *Medicare Part B prescription drug* benefit (see below).

Services that are covered for you	What you must pay when you get these services
• Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Prior authorization is required for certain drugs.**	
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. 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 When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.	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. **In-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
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider 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. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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 service 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.	

Services that are covered for you	What you must pay when you get these services
For drugs that may be covered by the plan's Part D benefit:If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. 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*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. *A physician or specialist copay 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	**In-Network:** 0% coinsurance per admission

Services that are covered for you	What you must pay when you get these services
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 • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services	**Out-of-Network:** 0% coinsurance 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
• 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 up to a $10,000 allowance (some restrictions apply). Items not directly related to travel and lodging expenses are not payable. Please contact Member Service for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	

Services that are covered for you	What you must pay when you get these services
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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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 services in a psychiatric hospital* 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.	**In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance 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) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	**In-Network:** $10 copay per primary care visit $20 copay per specialist visit 0% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for x-rays and diagnostic procedures 0% coinsurance for lab services and tests 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment $20 copay per therapy type, per provider, per visit for rehabilitation services **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• 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 ***Prior authorization is required for certain procedures and DME** ✓ *Inpatient hospital services when not covered or authorized by our plan do not count toward your out-of-pocket maximum.*	$10 copay per primary care visit $20 copay per specialist visit 0% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for each outpatient x-ray and diagnostic procedures 0% coinsurance for each lab service $20 copay per therapy type, per provider, per visit for rehabilitation services 10% coinsurance for DME, prosthetics and orthotics 10% coinsurance 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. *A physician or specialist copay 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
A physician 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. 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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan.	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for all other Part B drugs **Out-of-Network:** 0% coinsurance for all other Part B drugs

Services that are covered for you	What you must pay when you get these services
• The Alzheimer's drug, Leqembi® , (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	

Services that are covered for you	What you must pay when you get these services
• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv,® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit® or Aranesp®)	

Services that are covered for you	What you must pay when you get these services
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* 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 and the *Part D Prescription Drug Chart* in the back of the Annual Notice of Change.	
 **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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit..*
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	**In-Network:** $20 copay per individual or group visit

Services that are covered for you	What you must pay when you get these services
• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**Out-of-Network:** $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 (MRI, MRA, CT and PET scan) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Other outpatient diagnostic tests *Either the freestanding or outpatient facility lab copay may apply in a physician's office setting. If your physician sends your lab or*	**In-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office There is no coinsurance, copayment, or deductible for outpatient blood. *Separate physician and specialist visit cost sharing may apply.* **Out-of-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services

Services that are covered for you	What you must pay when you get these services
diagnostic test to another facility for analysis, you may be billed separately by the performing provider.	0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office
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/2021-10/11435-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.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D coverage. *Diagnostic testing will be subject to diagnostic cost sharing.* *Emergency Care cost sharing will apply if hospital observation is part of an emergency visit.*

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services*	**In-Network:**
We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • 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 • Advanced imaging services (MRI, MRA, CT and PET scan) • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or	$100 copay for emergency services 0% coinsurance per visit, per provider, per day for surgery performed in an ambulatory surgical center or outpatient hospital setting 0% coinsurance for partial hospitalization services $20 copay for each individual or group therapy visit for other mental health care services 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** $100 copay for emergency services 0% coinsurance per visit, per provider, per day for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services

Services that are covered for you	What you must pay when you get these services
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.	0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility $20 copay for each individual or group therapy visit for mental health services 10% coinsurance for Medicare-covered durable medical equipment (DME) items 0% coinsurance 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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-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).	**In-Network:** $20 copay per therapy, per provider, per visit **Out-of-Network:** $20 copay per therapy type, per provider, per visit
Outpatient substance use disorder services Individual and group therapy visits on an outpatient basis for substance use disorders.	**In-Network:** $20 copay per individual or group visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
	$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 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.	**In-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital **Out-of-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital
Partial hospitalization services and Intensive outpatient 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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Physician/Practitioner services, including doctor's office visits Covered services include:	Services that are available via telehealth are listed in the description of this benefit. The cost

Services that are covered for you	What you must pay when you get these services
• 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 • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance abuse, occupational, physical and speech therapies. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Telehealth services are available using interactive audio and video telecommunications on your computer, tablet or mobile device. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-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	sharing for an in-person or telehealth visit will be the same for the type of service. **In-Network:** $10 copay per primary care visit $20 copay per specialist visit $20 copay per non-routine (Medicare-covered) hearing visit $20 copay per non-routine (Medicare-covered) dental visit 0% coinsurance per service, per day, per provider for each ambulatory surgical center and/or outpatient hospital facility visit **Out-of-Network:** $10 copay per primary care visit $20 copay per specialist visit $20 copay per non-routine (Medicare-covered) dental visit $20 copay per non-routine (Medicare-covered) hearing visit 0% coinsurance per service, per day, per provider in an ambulatory surgical center and/or outpatient hospital facility

Services that are covered for you	What you must pay when you get these services
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and**	

Services that are covered for you	What you must pay when you get these services
◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • 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: • 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	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
Prosthetic and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	**In-Network:** 0% coinsurance for Medicare-covered items **Out-of-Network:** 10% coinsurance 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.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit
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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
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 50 – 80 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an 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 an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**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.
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.	**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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
We also cover up to two 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.	
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 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible) • 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	Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the in-network cost share. **Out-of-network coinsurance applies when enrollees choose to go to a non-network provider while <u>in</u> the Medicare Advantage National PPO service area**. **In-Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** $0 copay for kidney disease education services 10% coinsurance for renal dialysis

Services that are covered for you	What you must pay when you get these services
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 the *Evidence of Coverage*. 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.) • 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	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. **In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission

Services that are covered for you	What you must pay when you get these 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 or domestic partner is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
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.	
Telehealth - Remote Access Provides access to in-network visits using interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. Coverage is limited to the following conditions: • medication reconciliation post-discharge • nutritional counseling • pharmacy clinic counseling (chronic disease and medication management) Any other conditions or services would not be covered.	**In-Network:** $10 copay per PCP visit $20 copay per specialist visit **Out-of-Network:** $10 copay per primary care visit $20 copay per specialist visit

Services that are covered for you	What you must pay when you get these services
Transportation* Plan provides a benefit for up-to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits; appointments for dental, vision, hearing, and behavioral health services; and visits to pharmacies to pick up prescription drugs within a 50 mile limit. Destination must always be plan-approved. 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 Member Service at the phone number on the back of your ID card, 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday excluding holidays. TTY users should call 711 National Relay Service. ✓ *Transportation services do not apply to the maximum out-of-pocket.*	**In-Network:** ✓ $10 copay per one-way trip **Out-of-Network:** ✓ 50% coinsurance 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 A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the	**In and Out-of-Network (including worldwide):** $40 copay in-person or telehealth per visit *Not waived if admitted.*

Services that are covered for you	What you must pay when you get these services
plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. **Urgently needed services are covered worldwide.**	*Diagnostic testing may be subject to diagnostic cost sharing.*
 **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	**In-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
• 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.	
 **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 (or vaccines)), 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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Part D Prescription Drugs Chart

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.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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	31-day mail order not available	$12 copay	$12 copay
Cost Sharing Tier 2 (Generic)	$12 copay	31-day mail order not available	$12 copay	$12 copay

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 3 (Preferred Brand)	$35 copay	31-day mail order not available	$35 copay	$35 copay
Cost Sharing Tier 4* (Non-Preferred Drug)	$65 copay	31-day mail order not available	$65 copay	$65 copay
Cost Sharing Tier 5 (Specialty)	$65 copay	$65 copay	$65 copay	$65 copay

*You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost sharing tier.

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 100-day supply for Tiers 1 and 2. It is a 90-day supply for Tiers 3 and 4.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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) (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)	**Preferred Mail-order cost sharing** (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - 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)	$105 copay	$40 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$195 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 Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, you pay nothing for your covered Part D drugs.

Your cost for excluded drugs not covered by Part D but covered under our enhanced drug benefit will be the same as the Initial Coverage Stage.

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 and 40 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg and 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 and 20 mg	QL (0.2 EA per 1 day), *, +
Drisdol 1.25 MG (50,000 Unit)	*, +
Edex Kit 10 mcg, 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Ergocal Ciferol 1.25 mg	*, +
Folic Acid Tablet 1 mg	*, +
IFE-BIMIX 30/1 150-5 MG/5 ML	QL (0.2 EA per 1 day), *, +
IFE-PG20 100 MCG/5 ML VIAL	QL (0.2 EA per 1 day), *, +
Levitra Tablet 2.5 mg, 5 mg, 10 mg and 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), *, +
PAPAVRN 30 MG-PHENTO 1 MG/ML	QL (0.2 EA per 1 day), *, +
PPVRN 12MG-PHNT 1MG-ALPR 10MCG	QL (0.2 EA per 1 day), *, +
PPVRN 30MG-PHNT 1MG-ALPR 20MCG	QL (0.2 EA per 1 day), *, +
Promethazine HCL/Codeine Syrup 6.25-10/5	*, +
Promethazine DM Syrup 6.25-15/5	*, +
Sildenafil 25 MG, 50MG and 100 MG TABLET	QL (0.2 EA per 1 day), *, +
Staxyn Tablet, Disintegrating 10 mg	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg, 100 mg and 200 mg	*, +
Tadalafil 2.5 MG TABLET	QL (2 EA per 1 day), *, +
Tadalafil 5 MG TABLET	QL (1 EA per 1 day), *, +
Tadalafil 10 MG and 20 MG TABLET	QL (0.2 EA per 1 day), *, +
TRI-MIX 150 MG-5 MG-50 MCG VL	QL (0.2 EA per 1 day), *, +
Viagra Tablet 25 mg, 50 mg and 100 mg	QL (0.2 EA per 1 day), *, +
Vitamin D2 1.25MG(50,000 UNIT)	*, +
Vitamin D2 50 MCG (2,000 UNIT)	*, +

+ - 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.

Discrimination is Against the Law

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. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Qualified sign language interpreters
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802

(Expires 12/31/25)

Notification of Availability of Electronic Materials

If you requested that the *Evidence of Coverage* or *Formulary* be mailed annually, you will receive them by the end of October.

Beginning October 1, 2024, you can visit medicare.highmark.com to view and download these documents:

Evidence of Coverage: Please call Member Service at the number on the back of your ID card to request a printed copy.

Formulary: Click ***Find a Prescription Drug*** at the bottom of the website.

Provider/Pharmacy Directory: Click ***Find a Provider*** or ***Find a Pharmacy*** at the bottom of the website.

If you would prefer, you can call Member Service at the number on the back of your ID card to request a printed copy of the Formulary or directories.

Freedom Blue PPO Member 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. Member 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

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

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.

United Concordia is a separate company administering dental benefits. Davis Vision is a wholly-owned subsidiary of HVHC Inc. Onduo is an independent company that provides a diabetes management program on behalf of Highmark. FitOn Inc. is a separate company that administers fitness benefits. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit. Express Scripts is an independent company that administers the pharmacy benefit for your health plan. Vida is a separate company that provides cardiometabolic condition management services for certain eligible members of your health plan. Mental Well-Being is offered by your health plan and powered by Spring Health. Spring Health is an independent company that provides mental health care services through its agents.

And as I'm looking at these documents, there are two group numbers; 0198875 and 0178428. Can you explain the two groups so that I can try to point out the difference withthe naming convention?

HIGHMARK®
SENIOR HEALTH COMPANY

Freedom Blue PPO sponsored by The Pennsylvania State University (Group # 0198875) offered by Highmark Senior Health Company

Annual Notice of Changes for 2025

You are currently enrolled as a member of Freedom Blue PPO. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs.***

This document tells about the changes to your plan. It also provides complete Medical and Prescription Benefit Charts. To get more information about benefits or rules please call Member Service to ask us to mail you an *Evidence of Coverage*.

- **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.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 Drug List to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ 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 don't join another plan by December 7, 2024, you will stay in Freedom Blue PPO through your former employer/trust fund.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Freedom Blue PPO.
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member 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 call is free.
- This information is available in alternate formats such as large print and audio.
- **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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Freedom Blue PPO

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

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Freedom Blue PPO in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Deductible	$0 except for insulin furnished through an item of durable medical equipment.	$200 except for insulin furnished through an item of durable medical equipment.
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 **in-network** providers: $500 From **in-network and out-of-network** providers combined: $750	From **in-network** providers: $500 From **in-network and out-of-network** providers combined: $500
Doctor office visits	**Primary care visits:** **In-Network:** $10 copay per visit **Out-of-Network:** $10 copay per visit **Specialist visits:** **In-Network:** $20 copay per visit **Out-of-Network:** $20 copay per visit	**Primary care visits:** **In-Network:** $10 copay per visit **Out-of-Network:** $10 copay per visit **Specialist visits:** **In-Network:** $20 copay per visit **Out-of-Network:** $20 copay per visit
Inpatient hospital stays	**In-Network:** 0% of the total cost per admission **Out-of-Network:** 0% of the total cost per admission	**In-Network:** 0% of the total cost per admission **Out-of-Network:** 0% of the total cost per admission

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** $50 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • You may have cost sharing for excluded drugs that are covered under our enhanced drug benefit.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:**$12 copay • **Drug Tier 2:** $12 copay • **Drug Tier 3:** $35 copay • **Drug Tier 4:** $65 copay You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** $65 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for excluded drugs that are covered under our enhanced drug benefit.

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. Please see Section 6 regarding "Extra Help" from Medicare.

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

Medicare requires all health plans to limit how much you pay out of pocket for 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	2024 (this year)	2025 (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 applicable) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium (if applicable) and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$750	$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 or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at medicare.highmark.com. You may also call Member Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the *2025 Provider/ Pharmacy Directory* (medicare.highmark.com)to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the *2025 Provider/ Pharmacy Directory* (medicare.highmark.com) to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Service so we may assist.

Blue Cross Blue Shield Association Network Sharing

Participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are available in 48 states and 2 territories. 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 may 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 Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

	2024 (this year)	2025 (next year)
Diabetic Supplies	**In-Network:**	**In-Network:**

	2024 (this year)	2025 (next year)
	Abbott and Lifescan glucometers, diabetic test strips, lancets, and an Abbott continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).	Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott and Dexcom continuous glucose monitoring devices are now available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).
Emergency Care	You pay a $65 copay.	You pay a $100 copay.
Health & Wellness	**In-Network:** Access to SilverSneakers - a program with network gyms and fitness classes. **Out-of-Network:** $500 deductible then paid at 50% coinsurance for approved programs	Your plan provides a subscription to a fitness and health platform that gives you extra options - including access to a nationwide network of gyms, fitness studios, and community centers. This benefit also includes unlimited access to a digital library of at-home workouts, wellness and more. You will receive 32 credits each month to use towards memberships/classes at these gyms and fitness facilities. Members must create an account online via mobile app or website and then select the fitness facility. You may also contact Member Service for assistance in creating an account. You will be responsible for all fees that exceed the monthly credit balance. Unused credits will not roll over to the following month. More information on how credits are used will be provided by January 2025.

Section 1.5 – 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", which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Service for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

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 you haven't received this insert by December 15, 2024, please call Member Service and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Stage	2024 (this year)	2025 (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, 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.	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 $35 per prescription. **Tier 4 Non-Preferred Drug:** You pay $65 per prescription.

Stage	2024 (this year)	2025 (next year)
Most adult Part D vaccines are covered at no cost to you.	You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay $50 per prescription. Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty:** You pay $65 per prescription. Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at your attached *Prescription Drug Chart* and your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024	2025
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across

Description	2024	2025
		monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at 1-866-845-1803 (24 hours a day, 7 days a week) or visit Medicare.gov.
Member Service - Pharmacy	Not applicable	For pharmacy benefit questions or concerns, call: 1-866-675-8637 Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
Prior Authorization **(for in-network services)**	Authorization required for: • Partial Hospitalization • Outpatient Mental Health/Psychiatric services • Outpatient Substance Abuse/Opioid Treatment services • Outpatient Hospital Observation	Authorization requirement for services listed in 2024 column has been removed. Benefit categories that require authorization are marked with an asterisk (*) in the *Medical Benefits Chart*.

SECTION 3 Deciding Which Plan to Choose

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

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 31, you will automatically be enrolled in Freedom Blue PPO through your former employer/trust fund.

Section 3.2 – If you want to change plans

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

We hope to keep you as a member next year but if you want to change for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *– OR–* You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5) or call Medicare (see Section 7.2).

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 Member Service if you need more information on how to do so.
    - *– OR –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 31.** The change will take effect on January 1, 2025.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

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* document for a list of SHIP contact information by state.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office.

- **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.
- **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. To be eligible for the ADAP operating in your State, 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 or if you are currently enrolled how to continue receiving assistance, please see the *Agency Contact Information* appendix in the back of the *Evidence of Coverage* and call your state-specific program. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at the phone number on the back of your ID card or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Freedom Blue PPO

Questions? We're here to help. Please call Member Service at 1-866-918-5285. (TTY users should 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 2025 *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 2025. For details, look in the 2025 *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 Member 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 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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, equipment, and Part B prescription drugs) *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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- 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.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

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 2025* handbook. View it online at 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 will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

Medical Benefits Chart - 0198875

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

✓ You will see this symbol next to a service that does not apply to the Out-of-Pocket Maximum.

* You will see this symbol next to a service that requires prior authorization.

	In-Network	Out-of-Network
Plan Deductible	$200	
Plan Coinsurance	See Benefit detail below for in-network coinsurance	See Benefit detail below for out-of-network coinsurance
In-Network Out-of-Pocket Maximum	$500	
Combined Out-of-Pocket Maximum	$500	

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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer;	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS	

Services that are covered for you	What you must pay when you get these services
required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, 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. If the covered ambulance services are not for an emergency situation, it should be 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 (requires a Physician Certification Statement (PCS)) 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.**	**In-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 10% coinsurance per one way trip for <u>non-emergency</u> ambulance services Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.

Services that are covered for you	What you must pay when you get these services
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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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 are limited to: • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years	**In-Network:** 0% coinsurance **Out-of-Network:** 10% coinsurance
 **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	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
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.	*Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 (includes 3D mammogram) • One screening mammogram every calendar year for women aged 40 and older (includes 3D mammogram) • Clinical breast exams once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing. *A physician or specialist copay 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.	**In-Network:** $0 copay per service **Out-of-Network:** 0% coinsurance 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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which Medicare Part B cost sharing may apply. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you may have additional

Services that are covered for you	What you must pay when you get these services
• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	cost sharing that applies to the type of service received. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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, specialist or additional medically necessary diagnostic services cost sharing may*

Services that are covered for you	What you must pay when you get these services
	apply for any non-preventive services rendered at the time of the 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **Diabetes self-management training, diabetic services and supplies*** For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	**In-Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% coinsurance for diabetic supplies and therapeutic shoes Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott and Dexcom continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process). **Out-of-Network:** 10% coinsurance for diabetic supplies and therapeutic shoes

Services that are covered for you	What you must pay when you get these services
• 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 Member Service for details. • Certain DME providers in the Freedom Blue PPO network have agreed to provide blood glucose monitors free of charge. Call Member Service for details. ***Prior authorization is required for certain items**	*Physician or specialist cost sharing may apply for any non-preventive services also rendered at time of visit.*
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage*.) 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.	**In-Network:** 0% coinsurance for Medicare-covered DME items Your cost sharing for Medicare-covered oxygen equipment coverage is 0% coinsurance, every month. After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 0% coinsurance for the oxygen contents. **Out-of-Network:** 10% coinsurance for Medicare-covered DME items Your cost sharing is 10% coinsurance for Medicare-covered oxygen and oxygen related equipment *DME items must be purchased from a Medicare participating provider.*

Services that are covered for you	What you must pay when you get these services
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. ***Prior authorization is required for certain items**	
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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency care is covered worldwide.***	**In and Out-of-Network (including worldwide):** $100 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 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.
Enhanced disease management **Onduo/VerilyMe Diabetes Management** is a virtual care program that helps individuals manage their diabetes. The Type 1 and Type 2 diabetes programs help guide individuals to eat healthier, be more active, and create other lifestyle changes. It includes diabetes testing supplies, app experiences, and support from personal coaches, clinicians and care specialists, including access to physicians through	There is no cost to eligible members.

Services that are covered for you	What you must pay when you get these services
telemedicine when needed. To be eligible, the member must have diabetes and own a smartphone (to use the app). Other inclusion/ exclusion criteria may apply. **Highmark Mental Well-Being by Spring Health** offers a mental and behavioral health care program with digital tools/programs, coaching, and in-person and virtual clinical support to help members address a broad spectrum of behavioral health needs. **CHF and COPD management powered by Vida** offers a solution to treat and manage members with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). This program is only available using digital or smartphone technology. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments.	
 **Health and wellness education programs** You have access to a nationwide network of gyms, local fitness studios, and community centers through FitOn Health. The number of credits you receive are set each month and do not rollover. Your FitOn account offers unlimited access to a digital library without using any of your 32 monthly credits. The digital library includes: • At-home fitness and wellness classes • Meditation classes • Nutrition and meal planning • Lifestyle advice • And much more	**In-Network and Out-of-Network:** You receive 32 credits per month; ✓ You pay 100% for visits exceeding your credit allowance.

Services that are covered for you	What you must pay when you get these services
To learn more about FitOn Health and to search for participating gyms and studios, visit www.fitonhealth.com/medicare. You can also find the credit cost per gym by visiting the FitOn Health website or by calling **1-855-946-4036** (TTY 711). Customer Service hours of operation are Monday through Friday, 8:00 a.m. to 9:00 p.m. If the cost for gym memberships exceeds your 32 monthly credit allowance, you will be responsible for purchasing additional credits to cover the cost difference at that facility. ✓*Any amount paid for health and wellness services that exceed your monthly credit allowance are not subject to the maximum out-of-pocket.*	
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** (TTY users, 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:	**In-Network:** $20 copay per Medicare-covered 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 copay per Medicare-covered hearing exam ✓ $20 copay per annual routine hearing exam **In and Out-of-Network:** ✓ $500 allowance for any other hearing aids every 3 calendar years thru TruHearing or any other provider.

Services that are covered for you	What you must pay when you get these services
• first year of hearing aid purchase provider visits • 60-day trial period • 3 year extended warranty • 80 batteries per aid for non-rechargeable models Benefit <u>does not</u> include or cover any of the following: • Additional provider visits • Ear molds • Hearing aid accessories • Extra batteries • 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 copays are not subject to plan deductible, if applicable, 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 calendar year For women who are pregnant, we cover:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
• Up to three screening exams during a pregnancy	
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit Please reference *Durable medical equipment (DME) and related supplies* above for medical equipment and supplies.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to:	**In-Network:** 0% coinsurance per visit **Out-of-network:** 0% coinsurance per visit Medicare Part B drugs that are billed separately may be billed under the *Medicare Part B prescription drug* benefit (see below).

Services that are covered for you	What you must pay when you get these services
• Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Prior authorization is required for certain drugs.**	
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. 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 When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.	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. **In-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
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider 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. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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 service 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.	

Services that are covered for you	What you must pay when you get these services
For drugs that may be covered by the plan's Part D benefit:If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. 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*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. *A physician or specialist copay 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	**In-Network:** 0% coinsurance per admission

Services that are covered for you	What you must pay when you get these services
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 • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services	**Out-of-Network:** 0% coinsurance 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
• 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 up to a $10,000 allowance (some restrictions apply). Items not directly related to travel and lodging expenses are not payable. Please contact Member Service for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	

Services that are covered for you	What you must pay when you get these services
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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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 services in a psychiatric hospital* 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.	**In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance 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) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	**In-Network:** $10 copay per primary care visit $20 copay per specialist visit 0% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for x-rays and diagnostic procedures 0% coinsurance for lab services and tests 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment $20 copay per therapy type, per provider, per visit for rehabilitation services **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• 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 ***Prior authorization is required for certain procedures and DME** ✓ *Inpatient hospital services when not covered or authorized by our plan do not count toward your out-of-pocket maximum.*	$10 copay per primary care visit $20 copay per specialist visit 0% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for each outpatient x-ray and diagnostic procedures 0% coinsurance for each lab service $20 copay per therapy type, per provider, per visit for rehabilitation services 10% coinsurance for DME, prosthetics and orthotics 10% coinsurance 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. *A physician or specialist copay 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
A physician 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. 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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan.	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for all other Part B drugs **Out-of-Network:** 0% coinsurance for all other Part B drugs

Services that are covered for you	What you must pay when you get these services
• The Alzheimer's drug, Leqembi® , (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	

Services that are covered for you	What you must pay when you get these services
• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv,® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit® or Aranesp®)	

Services that are covered for you	What you must pay when you get these services
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* 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 and the *Part D Prescription Drug Chart* in the back of the Annual Notice of Change.	
 **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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit..*
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	**In-Network:** $20 copay per individual or group visit

Services that are covered for you	What you must pay when you get these services
• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**Out-of-Network:** $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 (MRI, MRA, CT and PET scan) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Other outpatient diagnostic tests *Either the freestanding or outpatient facility lab copay may apply in a physician's office setting. If your physician sends your lab or*	**In-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office There is no coinsurance, copayment, or deductible for outpatient blood. *Separate physician and specialist visit cost sharing may apply.* **Out-of-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services

Services that are covered for you	What you must pay when you get these services
diagnostic test to another facility for analysis, you may be billed separately by the performing provider.	0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office
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/2021-10/11435-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.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D coverage. *Diagnostic testing will be subject to diagnostic cost sharing.* *Emergency Care cost sharing will apply if hospital observation is part of an emergency visit.*

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services*	**In-Network:**
We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • 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 • Advanced imaging services (MRI, MRA, CT and PET scan) • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or	$100 copay for emergency services 0% coinsurance per visit, per provider, per day for surgery performed in an ambulatory surgical center or outpatient hospital setting 0% coinsurance for partial hospitalization services $20 copay for each individual or group therapy visit for other mental health care services 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** $100 copay for emergency services 0% coinsurance per visit, per provider, per day for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services

Services that are covered for you	What you must pay when you get these services
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.	0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility $20 copay for each individual or group therapy visit for mental health services 10% coinsurance for Medicare-covered durable medical equipment (DME) items 0% coinsurance 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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-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).	**In-Network:** $20 copay per therapy, per provider, per visit **Out-of-Network:** $20 copay per therapy type, per provider, per visit
Outpatient substance use disorder services Individual and group therapy visits on an outpatient basis for substance use disorders.	**In-Network:** $20 copay per individual or group visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
	$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 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.	**In-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital **Out-of-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital
Partial hospitalization services and Intensive outpatient 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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Physician/Practitioner services, including doctor's office visits Covered services include:	Services that are available via telehealth are listed in the description of this benefit. The cost

Services that are covered for you	What you must pay when you get these services
• 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 • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance abuse, occupational, physical and speech therapies. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Telehealth services are available using interactive audio and video telecommunications on your computer, tablet or mobile device. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-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	sharing for an in-person or telehealth visit will be the same for the type of service. **In-Network:** $10 copay per primary care visit $20 copay per specialist visit $20 copay per non-routine (Medicare-covered) hearing visit $20 copay per non-routine (Medicare-covered) dental visit 0% coinsurance per service, per day, per provider for each ambulatory surgical center and/or outpatient hospital facility visit **Out-of-Network:** $10 copay per primary care visit $20 copay per specialist visit $20 copay per non-routine (Medicare-covered) dental visit $20 copay per non-routine (Medicare-covered) hearing visit 0% coinsurance per service, per day, per provider in an ambulatory surgical center and/or outpatient hospital facility

Services that are covered for you	What you must pay when you get these services
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and**	

Services that are covered for you	What you must pay when you get these services
◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • 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: • 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	**In-Network:** $20 copay per Medicare-covered visit **Out-of-Network:** $20 copay per Medicare-covered visit
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
Prosthetic and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	**In-Network:** 0% coinsurance for Medicare-covered items **Out-of-Network:** 10% coinsurance 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.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit
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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
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 50 – 80 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an 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 an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**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.
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.	**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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
We also cover up to two 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.	
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 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible) • 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	Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the in-network cost share. **Out-of-network coinsurance applies when enrollees choose to go to a non-network provider while <u>in</u> the Medicare Advantage National PPO service area**. **In-Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** $0 copay for kidney disease education services 10% coinsurance for renal dialysis

Services that are covered for you	What you must pay when you get these services
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 the *Evidence of Coverage*. 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.) • 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	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. **In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission

Services that are covered for you	What you must pay when you get these 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 or domestic partner is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
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.	
Telehealth - Remote Access Provides access to in-network visits using interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. Coverage is limited to the following conditions: • medication reconciliation post-discharge • nutritional counseling • pharmacy clinic counseling (chronic disease and medication management) Any other conditions or services would not be covered.	**In-Network:** $10 copay per PCP visit $20 copay per specialist visit **Out-of-Network:** $10 copay per primary care visit $20 copay per specialist visit

Services that are covered for you	What you must pay when you get these services
Transportation* Plan provides a benefit for up-to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits; appointments for dental, vision, hearing, and behavioral health services; and visits to pharmacies to pick up prescription drugs within a 50 mile limit. Destination must always be plan-approved. 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 Member Service at the phone number on the back of your ID card, 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday excluding holidays. TTY users should call 711 National Relay Service. ✓ *Transportation services do not apply to the maximum out-of-pocket.*	**In-Network:** ✓ $10 copay per one-way trip **Out-of-Network:** ✓ 50% coinsurance 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 A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the	**In and Out-of-Network (including worldwide):** $40 copay in-person or telehealth per visit *Not waived if admitted.*

Services that are covered for you	What you must pay when you get these services
plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. **Urgently needed services are covered worldwide.**	*Diagnostic testing may be subject to diagnostic cost sharing.*
 **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	**In-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
• 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.	
 **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 (or vaccines)), 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, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Part D Prescription Drugs Chart

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.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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	31-day mail order not available	$12 copay	$12 copay
Cost Sharing Tier 2 (Generic)	$12 copay	31-day mail order not available	$12 copay	$12 copay

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 3 (Preferred Brand)	$35 copay	31-day mail order not available	$35 copay	$35 copay
Cost Sharing Tier 4* (Non-Preferred Drug)	$65 copay	31-day mail order not available	$65 copay	$65 copay
Cost Sharing Tier 5 (Specialty)	$65 copay	$65 copay	$65 copay	$65 copay

*You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost sharing tier.

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 100-day supply for Tiers 1 and 2. It is a 90-day supply for Tiers 3 and 4.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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) (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)	**Preferred Mail-order cost sharing** (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - 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)	$105 copay	$40 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$195 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 Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, you pay nothing for your covered Part D drugs.

Your cost for excluded drugs not covered by Part D but covered under our enhanced drug benefit will be the same as the Initial Coverage Stage.

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 and 40 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg and 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 and 20 mg	QL (0.2 EA per 1 day), *, +
Drisdol 1.25 MG (50,000 Unit)	*, +
Edex Kit 10 mcg, 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Ergocal Ciferol 1.25 mg	*, +
Folic Acid Tablet 1 mg	*, +
IFE-BIMIX 30/1 150-5 MG/5 ML	QL (0.2 EA per 1 day), *, +
IFE-PG20 100 MCG/5 ML VIAL	QL (0.2 EA per 1 day), *, +
Levitra Tablet 2.5 mg, 5 mg, 10 mg and 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), *, +
PAPAVRN 30 MG-PHENTO 1 MG/ML	QL (0.2 EA per 1 day), *, +
PPVRN 12MG-PHNT 1MG-ALPR 10MCG	QL (0.2 EA per 1 day), *, +
PPVRN 30MG-PHNT 1MG-ALPR 20MCG	QL (0.2 EA per 1 day), *, +
Promethazine HCL/Codeine Syrup 6.25-10/5	*, +
Promethazine DM Syrup 6.25-15/5	*, +
Sildenafil 25 MG, 50MG and 100 MG TABLET	QL (0.2 EA per 1 day), *, +
Staxyn Tablet, Disintegrating 10 mg	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg, 100 mg and 200 mg	*, +
Tadalafil 2.5 MG TABLET	QL (2 EA per 1 day), *, +
Tadalafil 5 MG TABLET	QL (1 EA per 1 day), *, +
Tadalafil 10 MG and 20 MG TABLET	QL (0.2 EA per 1 day), *, +
TRI-MIX 150 MG-5 MG-50 MCG VL	QL (0.2 EA per 1 day), *, +
Viagra Tablet 25 mg, 50 mg and 100 mg	QL (0.2 EA per 1 day), *, +
Vitamin D2 1.25MG(50,000 UNIT)	*, +
Vitamin D2 50 MCG (2,000 UNIT)	*, +

+ - 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.

Discrimination is Against the Law

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. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - — Qualified sign language interpreters
  - — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - — Qualified interpreters
  - — Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802

(Expires 12/31/25)

Notification of Availability of Electronic Materials

If you requested that the *Evidence of Coverage* or *Formulary* be mailed annually, you will receive them by the end of October.

Beginning October 1, 2024, you can visit medicare.highmark.com to view and download these documents:

Evidence of Coverage: Please call Member Service at the number on the back of your ID card to request a printed copy.

Formulary: Click ***Find a Prescription Drug*** at the bottom of the website.

Provider/Pharmacy Directory: Click ***Find a Provider*** or ***Find a Pharmacy*** at the bottom of the website.

If you would prefer, you can call Member Service at the number on the back of your ID card to request a printed copy of the Formulary or directories.

Freedom Blue PPO Member 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. Member 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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