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

Annual Notice of Changes for 2023

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 Services 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 authorization requirements and costs
- Think about how much you will spend on premiums, deductibles, and cost sharing

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

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

☐ 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 2023* handbook.

☐ 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, 2022, 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, 2023**. This will end your enrollment with Freedom Blue PPO.
- If you recently moved into, currently live in, or just moved out of 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.

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 information is available in alternate formats such as large print.
- **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 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 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Freedom Blue PPO in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From **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: $750
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 **Out-of-Network:** 0% of the total cost	**In-Network:** 0% of the total cost **Out-of-Network:** 0% of the total cost
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	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $12 copay

Cost	2022 (this year)	2023 (next year)
	• **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay • **Drug Tier 5:** $50 copay	• **Drug Tier 2:** $12 copay • **Drug Tier 3:** $20 copay • **Drug Tier 4:** $50 copay Insulin: $35 copay • **Drug Tier 5:** $50 copay

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 5 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	2022 (this year)	2023 (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	$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

Cost	2022 (this year)	2023 (next year)
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.		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	$750 Once you have paid $750 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

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.

There are changes to our network of providers for next year. **Please review the *2023 Provider/ Pharmacy Directory* 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 *2023 Provider/ Pharmacy Directory* 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 will pay higher cost sharing.

If your medical service is received in a county that does not participate in the Blue Cross and/or Blue Shield Medicare Advantage PPO Network, you can visit any provider that participates with Medicare and pay the in-network cost sharing amount.

Section 1.4 – Changes to 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.

	2022 (this year)	2023 (next year)
Enhanced Disease Management	Onduo Diabetes Management is not covered.	You pay nothing. Onduo Diabetes Management is a virtual care program that helps individuals manage their Type 2 diabetes. The program helps guide individuals to eat healthier, be more active, and create other lifestyle changes. It includes a smart blood glucose meter, the Onduo app, and support from personal coaches, clinicians and care specialists, including access to physicians through telemedicine when needed. To be eligible, you must have Type 2 diabetes, be 18 years of age or older and own a smartphone (to use the app).
Telehealth - Urgent Care	Urgent care not available.	You pay a $40 copay.

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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

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.

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, 2022, please call Member Service and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage (if applicable) and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call Member Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it's on or what stage you are in. **Please refer to your plan design below**.

Stage	2022 (this year)	2023 (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	2022 (this year)	2023 (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. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage* and the enclosed *Part D Prescription Drugs* appendix. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay $12 per prescription. **Tier 2 Generic:** You pay $12 per prescription. **Tier 3 Preferred Brand:** You pay $20 per prescription. **Tier 4 Non-Preferred Drug:** You pay $50 per prescription. **Tier 5 Specialty:** You pay $50 per prescription. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay $12 per prescription. **Tier 2 Generic:** You pay $12 per prescription. **Tier 3 Preferred Brand:** You pay $20 per prescription. **Tier 4 Non-Preferred Drug:** You pay $50 per prescription. You pay $35 per insulin prescription. **Tier 5 Specialty:** You pay $50 per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Freedom Blue PPO

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

Section 2.2 – If you want to change plans

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

We hope to keep you as a member next year but if you want to change for 2023 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 2023* handbook, call your State Health Insurance Assistance Program (see Section 4) or call Medicare (see Section 6.2).

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 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 31.** The change will take effect on January 1, 2023.

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, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of 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.

SECTION 4 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 5 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. 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 (applications).

- **Help from your state's pharmaceutical assistance program.** Many states have a program called State Pharmaceutical Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through your state's ADAP program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please see the *Agency Contact Information* appendix in the back of the *Evidence of Coverage* and call your state-specific program.

SECTION 6 Questions?

Section 6.1 – Getting Help from Freedom Blue PPO

Questions? We're here to help. Please call Member Service at 1-866-918-5285. (TTY only, call 711 National Relay Service.) We are available for phone calls Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Calls to these numbers are free.

Read your 2023 *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 2023. For details, look in the 2023 *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 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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 2023*

You can read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this 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.
- Some of the services listed in the *Medical Benefits Chart* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Freedom Blue PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the *Medical Benefits Chart*.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* 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 2023, either Medicare or our plan will cover those services.

Medical Benefits Chart

 **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.

	In-Network	Out-of-Network
Plan Deductible	None	
Plan Coinsurance	0%	See Benefit detail below for out-of-network coinsurance
In-Network Out-of-Pocket Maximum	$500	
Combined Out-of-Pocket Maximum	$750	

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
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 visit **Out-of-Network:** $20 copay per 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 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. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. To meet this definition, the member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the member is bed-confined, and it is documented that the member's condition is such that other methods of transportation are contraindicated; or, if the member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. <u>Prior Authorization Requirements</u> All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member's non-emergent ambulance provider is responsible for obtaining prior authorization. Any non-emergency transportation services not prior authorized will not be covered.	**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 non-emergency ambulance services *Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Non-emergency ambulance services require a Physician Certification Statement (PCS).* Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.

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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
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

Services that are covered for you	What you must pay when you get these services
 **Bone mass measurement** For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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

Services that are covered for you	What you must pay when you get these services
 **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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
Chiropractic services* Covered services include:	**In-Network:** $20 copay per Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
• We cover only manual manipulation of the spine to correct subluxation	**Out-of-Network:** $20 copay per Medicare-covered visit
 **Colorectal cancer screening** For people 45 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening CT Colonography for people ages 45-75 years old once every five years One of the following every calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If the screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and outpatient surgery cost sharing may apply. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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. *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
	Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.
 **Diabetes screening** We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
 **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.	**In-Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% coinsurance for diabetic supplies and therapeutic shoes **Out-of-Network:** 10% coinsurance for diabetic supplies and therapeutic shoes *Physician or specialist cost sharing may apply for any non-preventive services also rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
• Diabetes self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests are covered 2 times per calendar year. • You must obtain diabetic testing supplies from Durable Medical Equipment (DME) suppliers. Diabetic testing supplies may be covered if purchased at an approved retail pharmacy. Call 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**	
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 and 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.	**In-Network:** **Durable Medical Equipment:** 0% coinsurance for Medicare-covered items Your cost sharing for Medicare 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:** **Durable Medical Equipment:** 10% coinsurance for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 10% coinsurance for oxygen and oxygen related equipment

Services that are covered for you	What you must pay when you get these services
Reimbursement for oxygen services includes payment for equipment rental, oxygen contents, and all accessories and supplies as necessary. Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established. ***Prior authorization is required for certain items**	*DME items must be purchased from a Medicare participating provider.*
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):** $65 copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment as these are not considered hospital admissions. If you receive emergency care at an out-of-network hospital and need inpatient care 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 Diabetes Management is a virtual care program that helps individuals manage their Type 2 diabetes. The program helps guide individuals to eat healthier, be more active, and create other lifestyle changes.	There is no cost to eligible members. To be eligible, the member must have Type 2 diabetes, be 18 years of age or older and own a smartphone (to use the app).

Services that are covered for you	What you must pay when you get these services
It includes a smart blood glucose meter, the Onduo app, and support from personal coaches, clinicians and care specialists, including access to physicians through telemedicine when needed.	
Health and wellness education programs Highmark's health and wellness education program provides access to network gyms and fitness classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination through the Tivity, Inc. SilverSneakers® Fitness program. Eligible members receive a membership at network fitness facilities with access to all basic amenities plus SilverSneakers® fitness classes. SilverSneakers FLEX™ classes (which include tai chi, yoga and dance) are in neighborhood locations such as medical campuses, older-adult living communities and parks. SilverSneakers Steps®, which includes various kits for members to use at home or when they travel, is an available alternative for members who can't get to a network fitness location. For more information, to find SilverSneakers fitness locations and FLEX™ classes, or to get started with SilverSneakers Steps®, eligible members should visit silversneakers.com or call **1-888-423-4632** (TTY: 711 National Relay Service), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.	**In-Network:** There is no charge for the fitness program. **Out-of-Network:** ✓ Because of the unique nature of health and wellness programs, the availability of comparable, equivalent programs may be limited. Program membership or monthly dues that qualify for benefit coverage are subject to a 50% coinsurance after satisfying a $500 deductible which is not applied to the medical out-of-pocket maximum.
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.	**In-Network:** $20 copay per Medicare-covered hearing exam ✓ $20 copay per annual routine hearing exam

Services that are covered for you	What you must pay when you get these services
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: • 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 cost for optional hearing aid rechargeability • 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.	✓ $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
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: • Up to three screening exams during a pregnancy	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
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	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
• Medical equipment and supplies 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: • 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.**	**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).
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	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

Services that are covered for you	What you must pay when you get these services
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. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay 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. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> 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).	**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
• 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 services For services that are covered by Freedom Blue PPO but are not covered by Medicare Part A or B: Freedom Blue PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: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:	**In and Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, 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 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: • COVID-19 related services and stay requirements • 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	If a patient is admitted for an Inpatient Acute Hospital Care stay due to COVID-19, the cost share for this service will be waived both in and out-of-network. Inpatient rehabilitation is not included. **In-Network:** 0% coinsurance per admission **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
• Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Freedom Blue PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion 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	

Services that are covered for you	What you must pay when you get these services
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. 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.	
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)	**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

Services that are covered for you	What you must pay when you get these services
• X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	0% coinsurance for oxygen and oxygen related equipment $20 copay per therapy type, per provider, per visit for rehabilitation services **Out-of-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 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,	**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.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*

Services that are covered for you	What you must pay when you get these services
you may be able to receive more hours of treatment with a physician's order. 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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, toxoids, pathology drugs, laboratory drugs, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs

Services that are covered for you	What you must pay when you get these services
• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com We also cover some vaccines under our Part B and 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	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
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.*	*A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
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: • 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 counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-Network:** $20 copay per individual or group visit **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	**In-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services $0 copay for therapeutic radiology services 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) 0% coinsurance for lab services performed in an outpatient hospital facility

Services that are covered for you	What you must pay when you get these services
• Laboratory tests • Advanced imaging services • 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 diagnostic test to another facility for analysis, you may be billed separately by the performing provider.*	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 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) 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	**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.*

Services that are covered for you	What you must pay when you get these services
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.	*Emergency Care cost sharing will apply if hospital observation is part of an emergency visit.*
Outpatient hospital services*	**In-Network:** $65 copay for emergency services

Services that are covered for you	What you must pay when you get these services
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 • 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 by calling 1-800-MEDICARE (1-800-633-4227). TTY users call	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 copay for therapeutic radiology services 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) 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:** $65 copay for emergency services 0% coinsurance 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 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan)

Services that are covered for you	What you must pay when you get these services
1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	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, nurse practitioner, physician assistant, 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 abuse services* Individual and group therapy visits on an outpatient basis for substance abuse.	**In-Network:** $20 copay per individual or group visit **Out-of-Network:** $20 copay per individual or group visit

Services that are covered for you	What you must pay when you get these services
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 **Out-of-Network:** 0% coinsurance per service, per day, per provider
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance	Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person or telehealth visit will be the same for the type of service. **In-Network:** $10 copay per primary care in-person or telehealth visit $20 copay per specialist in-person or telehealth visit $20 copay per non-routine (Medicare-covered) dental in-person visit $20 copay per non-routine (Medicare-covered) hearing in-person visit 0% coinsurance per service, per day, per provider for each ambulatory surgical center and/or outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
abuse, occupational, physical and speech therapies, and urgent care. ◦ 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 • 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	**Out-of-Network:** $10 copay per primary care in-person or telehealth visit $20 copay per specialist in-person or telehealth visit $20 copay per non-routine (Medicare-covered) dental in-person visit $20 copay per non-routine (Medicare-covered) hearing in-person visit 0% coinsurance for services at an ambulatory surgical center and/or outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
◦ 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** ◦ 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	

Services that are covered for you	What you must pay when you get these services
• 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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic	**In-Network:** 0% coinsurance for Medicare-covered items **Out-of-Network:** 10% coinsurance for Medicare-covered items

Services that are covered for you	What you must pay when you get these services
devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	
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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
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 a written order for LDCT during a lung cancer screening counseling and shared decision making visit	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
Services to treat kidney disease Covered services include:	Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the network cost share. Maximum

Services that are covered for you	What you must pay when you get these services
• 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 information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	coinsurance applies when enrollees choose to go to a non-network provider while in the Medicare Advantage National PPO service area. **In-Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** 10% coinsurance for renal dialysis
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	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

Services that are covered for you	What you must pay when you get these services
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 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)	begins. There is no limit to the number of benefit periods you can have. **In-Network:** 0% coinsurance per admission for days 1-100 **Out-of-Network:** 0% coinsurance per admission for days 1-100

Services that are covered for you	What you must pay when you get these services
• A SNF where your spouse is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** 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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office	**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
• 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
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.	**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

Services that are covered for you	What you must pay when you get these services
Mode of transportation could include van, medical transport, wheelchair van, or car at the discretion of the plan. If you pay out of pocket for these modes of transportation, reimbursement may be provided in special circumstances at the discretion of the plan; however, personal vehicle expenses will not be considered for reimbursement. Plan authorization and scheduling rules apply. Any routine transportation services not scheduled through the plan or prior-authorized will not be covered. To obtain prior authorization and schedule a pickup, please call us **at least 48 hours in advance**. Contact Customer Service at the phone number on the back of your ID card, 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday excluding holidays. TTY users should call 711 National Relay Service. ✓ *Transportation services do not apply to the maximum out-of-pocket.*	from an emergency room does not apply towards the trip limit. This is limited to a one way trip to the home and any round-trip to a physician's office related to the emergency condition.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	**In and Out-of-Network (including worldwide):** $40 copay in-person or telehealth per visit *Not waived if admitted.* *Diagnostic testing may be subject to diagnostic cost sharing.*

Services that are covered for you	What you must pay when you get these services
Urgently needed services are covered worldwide.	
 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) A $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	**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
 **"Welcome to Medicare" preventive visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.* *Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.*

Part D Prescription Drugs Chart

Please note: Because your prescription coverage is better than the CMS Defined Standard Part D benefit, some drug coverage is provided through a Prescription Drug Coverage Gap Health Care Product, which is separate from your Freedom Blue PPO coverage.

The Deductible Stage

There is no deductible for Freedom Blue PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See below for information about your coverage in the Initial Coverage Stage.

The Initial Coverage Stage

A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

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

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

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

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 2 (Generic)	$12 copay	31-day mail order not available	$12 copay	$12 copay
Cost Sharing Tier 3 (Preferred Brand)	$20 copay	31-day mail order not available	$20 copay	$20 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$50 copay Insulin: $35 copay	31-day mail order not available	$50 copay Insulin: $35 copay	$50 copay Insulin: $35 copay
Cost Sharing Tier 5 (Specialty)	$50 copay	$50 copay	$50 copay	$50 copay

A table that shows your costs for a *long-term* up to a 90-day supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply.

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

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard retail cost sharing (in-network) (up to a 90-day supply)	**Preferred Mail-order cost sharing** (up to a 90-day supply)
Cost Sharing Tier 1 (Preferred Generic)	$36 copay	$24 copay
Cost Sharing Tier 2 (Generic)	$36 copay	$24 copay
Cost Sharing Tier 3 (Preferred Brand)	$60 copay	$40 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$150 copay Insulin: $105 copay	$100 copay
Cost Sharing Tier 5 (Specialty)	*A long-term supply is not available for drugs in Specialty Tier 5*	*A long-term supply is not available for drugs in Specialty Tier 5*

The Coverage Gap Stage

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $7,400. When you reach an out-of-pocket limit of $7,400, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Your prescription cost sharing while in the Coverage Gap is the same as your cost sharing in the Initial Coverage Stage. Please see the above charts.

The Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - –*either* – Coinsurance of 5% of the cost of the drug

- –*or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.

- **Our plan pays the rest** of the cost.

Important Information about Certain Medicare Excluded Prescription Drugs

The following is a list of Medicare Part D excluded drugs covered under your plan. The cost sharing for these drugs is Generic-Tier 2 and Brand-Tier 4 listed in your plan documents.

Drug Name	Requirements/Limits
Caverject Vial (ea) 20 mcg 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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចាំបាច់ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

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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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