HIGHMARK

CENTRAL PENNSYLVANIA

Freedom Blue PPO

Summary of Benefits

January 1, 2022 to December 31, 2022

The service area for these plans includes the following counties:

Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York

To enroll in the following plans, you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of the above listed counties.

To contact us about Freedom Blue PPO, call 1-866-743-5478 (TTY users call 711), 8:00 a.m. to 8:00 p.m., seven days a week or visit medicare.highmark.com.

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CENTRAL PENNSYLVANIA

This section is a summary of benefits. It doesn't list every service, limitation, or special circumstance. If you want the whole kit and caboodle — the full Evidence of Coverage — call the number on the plan page you're looking for.

How to Find a Provider or Pharmacy

Freedom Blue PPO has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at **medicare.highmark.com**. Or, call us and we'll send you a copy of the provider and pharmacy directories.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.highmark.com**. Or, call us and we'll send you a copy of the formulary.

More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get 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.

Out-Of-Network Benefit

The Out-Of-Network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

CENTRAL PENNSYLVANIA

	Freedom Blue PPO Deluxe	Freedom Blue PPO Standard
Premium	$288.00	$174.00
Deductible	$0	$0
Max Out-Of-Pocket	$4,500 IN; $10,000 Catastrophic	$5,000 IN; $10,000 Catastrophic
Inpatient Hospital Stay	$235 copay per admit IN*; $235 copay per admit OON	$475 copay per admit IN*; $475 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $100 copay IN*; $100 copay OON Facility: $200 copay IN*; $200 copay OON	ASC[1]: $150 copay IN*; $150 copay OON Facility: $250 copay IN*; $250 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $30 copay IN; $30 copay OON	PCP: $0 copay IN; $0 copay OON Specialist: $35 copay IN; $35 copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	Covered in Full (Office visit copay may apply) IN/OON
Emergency Room	$90 copay IN/OON	$90 copay IN/OON
Urgently Needed Services	$50 copay IN/OON	$50 copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 copay IN*; $10 copay OON Outpatient: $10 copay IN*; $10 copay OON	Office/Lab: $0 copay IN*; $15 copay OON Outpatient: $15 copay IN*; $15 copay OON
X-Rays/ Advanced Imaging	X-ray: $10 copay IN*; $10 copay OON Advanced Imaging: $100 copay IN*; $100 copay OON	X-ray: $20 copay IN*; $20 copay OON Advanced Imaging: $150 copay IN*; $150 copay OON
Hearing Services	Medicare Covered: $30 copay IN; $30 copay OON. Routine: $0 copay IN; $30 copay OON (1 Per Year). TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay (2 Aids Every Year IN); $500 allowance IN/OON (per year)	Medicare Covered: $35 copay IN; $35 copay OON. Routine: $0 copay IN; $35 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year IN); $500 allowance IN/OON (per year)
Dental Services	Medicare Covered: $30 copay IN; $30 copay OON. Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $15 copay IN; 30% coinsurance OON (1 per year).	Medicare Covered: $35 copay IN; $35 copay OON. Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $15 copay IN; 30% coinsurance OON (1 per year).
Vision Services	Medicare Covered: $30 copay IN; $30 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).	Medicare Covered: $35 copay IN; $35 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: $235 copay per admit IN*; $235 copay per admit OON; Outpatient: $30 copay IN*; $30 Copay OON	Inpatient: $475 copay per admit IN*; $475 copay per admit OON; Outpatient: $35 copay IN*; $35 Copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $188 copay/day (days 21-100) IN*; 30% coinsurance OON	$0 copay/day (days 1-20), $188 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$30 copay IN*; $30 copay OON	$35 copay IN*; $35 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $150 copay IN**; Non-Emergent: 30% coinsurance OON	Emergent/Non-Emergent: $225 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation (up-to 24 one-way trips)	$0 copay IN*; 30% coinsurance OON	$0 copay IN*; 30% coinsurance OON
Part B Drugs	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Routine Podiatry	$30 copay IN; $30 copay OON (12 visits per year)	$35 copay IN; $35 copay OON (10 visits per year)
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Fitness Benefit	Covered in full IN; 50% coinsurance after satisfying a $500 deductible OON	Covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Venture	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

	Freedom Blue PPO ValueRx	Freedom Blue PPO Basic
Premium	$69.00	$65.00
Deductible	$0	$0
Max Out-Of-Pocket	$5,500 IN; $10,000 Catastrophic	$5,900 IN; $10,000 Catastrophic
Inpatient Hospital Stay	Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit IN*; Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit OON	$340 copay per admit IN*; $340 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $200 copay IN*; $200 copay OON Facility: $275 copay IN*; $275 copay OON	ASC[1]: $100 copay IN*; $100 copay OON Facility: $200 copay IN*; $200 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $40 copay IN; $40 copay OON	PCP: $0 copay IN; $0 copay OON Specialist: $35 copay IN; $35 copay OON
Preventive/Screening	Covered in Full (Office visit copay may apply) IN/OON	Covered in Full (Office visit copay may apply) IN/OON
Emergency Room	$90 copay IN/OON	$90 copay IN/OON
Urgently Needed Services	$50 copay IN/OON	$50 copay IN/OON
Lab & Diagnostic Tests	Office/Lab: $0 copay IN*; $20 copay OON Outpatient: $20 copay IN*; $20 copay OON	Office/Lab: $0 copay IN*; $20 copay OON Outpatient: $20 copay IN*; $20 copay OON
X-Rays/ Advanced Imaging	X-ray: $25 copay IN*; $25 copay OON Advanced Imaging: $200 copay IN*; $200 copay OON	X-ray: $25 copay IN*; $25 copay OON Advanced Imaging: $150 copay IN*; $150 copay OON
Hearing Services	Medicare Covered: $40 copay IN; $40 copay OON. Routine: $0 copay IN; $40 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year IN); $500 allowance IN/OON (per year)	Medicare Covered: $35 copay IN; $35 copay OON. Routine: $0 copay IN; $35 copay OON (1 Per Year). TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay (2 Aids Every Year IN); $500 allowance IN/OON (per year)
Dental Services	Medicare Covered: $40 copay IN; $40 copay OON. Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $15 copay IN; 30% coinsurance OON (1 per year).	Medicare Covered: $35 copay IN; $35 copay OON. Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning. X-Rays: $15 copay IN; 30% coinsurance OON (1 per year).
Vision Services	Medicare Covered: $40 copay IN; $40 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).	Medicare Covered: $35 copay IN; $35 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $150 benefit max applies to non-standard frames or a $150 benefit max for specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit IN*; Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit OON; Outpatient: $40 copay IN*; $40 Copay OON	Inpatient: $340 copay per admit IN*; $340 copay per admit OON; Outpatient: $35 copay IN*; $35 Copay OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $188 copay/day (days 21-100) IN*; 30% coinsurance OON	$0 copay/day (days 1-20), $188 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$40 copay IN*; $40 copay OON	$35 copay IN*; $35 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $285 copay IN**; Non-Emergent: 30% coinsurance OON	Emergent/Non-Emergent: $125 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation (up-to 24 one-way trips)	$0 copay IN*; 30% coinsurance OON	$0 copay IN*; 30% coinsurance OON
Part B Drugs	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Routine Podiatry	$40 copay IN; $40 copay OON (8 visits per year)	$35 copay IN; $35 copay OON (10 visits per year)
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Fitness Benefit	Covered in full IN; 50% coinsurance after satisfying a $500 deductible OON	Covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Performance	Not offered

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips.

ASC[1]=Ambulatory Surgery Center

Freedom Blue PPO Deluxe

DRUG

You pay the following until your total yearly drug costs reach $4,430.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.

See Table Below

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,050, you pay the greater of: 5% of the cost, or $3.95 Copay for generics and a $9.85 Copay for all other drugs.

Greater of: 5% or $3.95 Generic / Preferred Multi-Source or $9.85 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Freedom Blue PPO Standard

DRUG

You pay the following until your total yearly drug costs reach $4,430.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,050, you pay the greater of: 5% of the cost, or $3.95 Copay for generics and a $9.85 Copay for all other drugs.

Greater of: 5% or $3.95 Generic / Preferred Multi-Source or $9.85 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Freedom Blue PPO ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,430.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Initial Coverage

Preferred Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Retail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$15 Copay
Tier 2 (Generic)	$19 Copay	$57 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$27 Copay
Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,050, you pay the greater of: 5% of the cost, or $3.95 Copay for generics and a $9.85 Copay for all other drugs.

Greater of: 5% or $3.95 Generic / Preferred Multi-Source or $9.85 for all others

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Freedom Blue PPO Deluxe			
Coverage Gap	Preferred Network	Tier	
		Tier 1 (Preferred Generic)	$0 Copay
		Tier 2 (Generic)	$13 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount
	Standard Network	Tier	
		Tier 1 (Preferred Generic)	$5 Copay
		Tier 2 (Generic)	$19 Copay
		Tier 3-5 (Generic)	25% Coinsurance
		Brand	25% Coinsurance including 70% discount

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Cross Blue Shield provides certain administrative communications for this company. Highmark Blue Cross Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross Blue Shield Association. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 1-866-743-5478 (TTY users may call 711) for more information.