HIGHMARK

**WEST CENTRAL PENNSYLVANIA**

## Freedom Blue PPO

# Summary of Benefits

**January 1, 2023 to December 31, 2023**

**The service area for these plans includes the following counties:**

**Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, Warren**

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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# WEST 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."

| | Freedom Blue PPO Valor | Freedom Blue PPO ValueRx |
|---|---|---|
| Premium | $0.00 | $68.00 |
| Part B Premium Reduction | $60.00 | $0.00 |
| Deductible | $0 | $0 |
| Max Out-Of-Pocket | $6,000 IN; $8,950 combined IN and OON | $5,500 IN; $8,950 combined IN and OON |
| Inpatient Hospital Stay | $275 copay per admit IN*; $395 copay per admit OON | Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit IN*; Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit OON |
| Outpatient Hospital Coverage | ASC[1]: $195 copay IN*; $325 copay OON<br>Facility: $245 copay IN*; $375 copay OON | ASC[1]: $175 copay IN*; $175 copay OON<br>Facility: $200 copay IN*; $200 copay OON |
| Doctor Office Visit | PCP: $0 copay IN; $0 copay OON<br>Specialist: $10 copay IN; $10 copay OON | PCP: $0 copay IN; $0 copay OON<br>Specialist: $40 copay IN; $40 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 | $95 copay IN/OON | $95 copay IN/OON |
| Urgently Needed Services | $50 copay IN/OON | $5 copay IN/OON |
| Lab & Diagnostic Tests | Office/Lab: $0 copay IN*; $35 copay OON<br>Outpatient: $0 copay IN*; $35 copay OON | Office/Lab: $0 copay IN*; $20 copay OON<br>Outpatient: $20 copay IN*; $20 copay OON |
| X-Rays/ Advanced Imaging | X-ray: $20 copay IN*; $35 copay OON<br>Advanced Imaging: $225 copay IN*; $325 copay OON | X-ray: $20 copay IN*; $20 copay OON<br>Advanced Imaging: $200 copay IN*; $200 copay OON |
| Hearing Services | Medicare Covered: $10 copay IN; $10 copay OON.<br>Routine: $10 copay IN; $10 copay OON (1 Per Year).<br>(2 Aids Every Year IN); $500 allowance IN/OON (per year)<br>TruHearing Advanced: $699 copay;<br>TruHearing Premium: $999 copay | Medicare Covered: $40 copay IN; $40 copay OON.<br>Routine: $0 copay IN; $40 copay OON (1 Per Year).<br>(2 Aids Every Year IN); $500 allowance IN/OON (per year)<br>TruHearing Advanced: $699 copay;<br>TruHearing Premium: $999 copay |
| Dental Services | Medicare Covered: $10 copay IN; $10 copay OON.<br>Office Visit: $0 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning.<br>X-Rays: $0 copay IN; 30% coinsurance OON (1 per year).<br>Comprehensive: 50% coinsurance with a maximum $3,000 allowance IN/OON (Per Year) | Medicare Covered: $40 copay IN; $40 copay OON.<br>Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning.<br>X-Rays: $15 copay IN; 30% coinsurance OON (1 per year). |
| Vision Services | Medicare Covered: $10 copay IN; $10 copay OON.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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: $40 copay IN; $40 copay OON.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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 - 3: $325 copay per day per admit & Days 4 - 90: $0 copay per day per admit IN*; Days 1 - 3: $475 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON; Outpatient: $5 copay IN*; $35 copay OON | Inpatient: Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per day per admit IN*; Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per day per admit OON; Outpatient: $40 copay IN*; $40 copay OON |
| Skilled Nursing Facility | $0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON | $0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON |
| Physical Therapy | $15 copay IN*; $35 copay OON | $40 copay IN*; $40 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: $250 copay IN**;<br>Non-Emergent: 30% coinsurance OON | Emergent/Non-Emergent: $275 copay IN**;<br>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 |
| OTC | $100 allowance once per quarter IN/OON | Not Covered |
| Routine Podiatry | $10 copay IN; $10 copay OON (10 visits per year) | $40 copay IN; $40 copay OON (8 visits per year) |
| Durable Medical Equipment | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |
| Fitness Benefit | Silver Sneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON | Silver Sneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON |
| Formulary | N/A | Performance |

| | Freedom Blue PPO Select | Freedom Blue PPO Classic |
|---|---|---|
| Premium | $127.00 | $250.00 |
| Part B Premium Reduction | $0.00 | $0.00 |
| Deductible | $0 | $0 |
| Max Out-Of-Pocket | $5,000 IN; $8,950 combined IN and OON | $4,500 IN; $8,950 combined IN and OON |
| Inpatient Hospital Stay | $350 copay per admit IN*; $350 copay per admit OON | $210 copay per admit IN*; $210 copay per admit OON |
| Outpatient Hospital Coverage | ASC[1]: $125 copay IN*; $125 copay OON<br>Facility: $175 copay IN*; $175 copay OON | ASC[1]: $75 copay IN*; $75 copay OON<br>Facility: $150 copay IN*; $150 copay OON |
| Doctor Office Visit | PCP: $0 copay IN; $0 copay OON<br>Specialist: $30 copay IN; $30 copay OON | PCP: $0 copay IN; $0 copay OON<br>Specialist: $25 copay IN; $25 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 | $95 copay IN/OON | $95 copay IN/OON |
| Urgently Needed Services | $5 copay IN/OON | $5 copay IN/OON |
| Lab & Diagnostic Tests | Office/Lab: $0 copay IN*; $15 copay OON<br>Outpatient: $15 copay IN*; $15 copay OON | Office/Lab: $0 copay IN*; $10 copay OON<br>Outpatient: $10 copay IN*; $10 copay OON |
| X-Rays/ Advanced Imaging | X-ray: $20 copay IN*; $20 copay OON<br>Advanced Imaging: $125 copay IN*; $125 copay OON | X-ray: $15 copay IN*; $15 copay OON<br>Advanced Imaging: $100 copay IN*; $100 copay OON |
| Hearing Services | Medicare Covered: $30 copay IN; $30 copay OON.<br>Routine: $0 copay IN; $30 copay OON (1 Per Year).<br>(2 Aids Every Year IN); $500 allowance IN/OON (per year)<br>TruHearing Advanced: $699 copay;<br>TruHearing Premium: $999 copay | Medicare Covered: $25 copay IN; $25 copay OON.<br>Routine: $0 copay IN; $25 copay OON (1 Per Year).<br>(2 Aids Every Year IN); $500 allowance IN/OON (per year)<br>TruHearing Advanced: $699 copay;<br>TruHearing Premium: $999 copay |
| Dental Services | Medicare Covered: $30 copay IN; $30 copay OON.<br>Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning.<br>X-Rays: $15 copay IN; 30% coinsurance OON (1 per year). | Medicare Covered: $25 copay IN; $25 copay OON.<br>Office Visit: $15 copay IN; 30% coinsurance OON (1 per six months). Office visit includes a cleaning.<br>X-Rays: $15 copay IN; 30% coinsurance OON (1 per year). |
| Vision Services | Medicare Covered: $30 copay IN; $30 copay OON.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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: $25 copay IN; $25 copay OON.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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: $350 copay per admit IN*; $350 copay per admit OON; Outpatient: $30 copay IN*; $30 copay OON | Inpatient: $210 copay per admit IN*; $210 copay per admit OON; Outpatient: $25 copay IN*; $25 copay OON |
| Skilled Nursing Facility | $0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON | $0 copay/day (days 1-20), $196 copay/day (days 21-100) IN*; 30% coinsurance OON |
| Physical Therapy | $30 copay IN*; $30 copay OON | $25 copay IN*; $25 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: $215 copay IN**;<br>Non-Emergent: 30% coinsurance OON | Emergent/Non-Emergent: $165 copay IN**;<br>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 |
| OTC | Not Covered | Not Covered |
| Routine Podiatry | $30 copay IN; $30 copay OON (10 visits per year) | $25 copay IN; $25 copay OON (12 visits per year) |
| Durable Medical Equipment | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |
| Fitness Benefit | Silver Sneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON | Silver Sneakers 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

†Certain rebatable drugs may be subject to a lower coinsurance. After 7/1/2023, Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

## Freedom Blue PPO ValueRx

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| | | | | |
|---|---|---|---|---|
| **Deductible** | $0 | | | |
| **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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $45 Copay | $135 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $47 Copay | $141 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | $100 Copay | $300 Copay |
| | | Tier 5 (Specialty Tier) | 33% of the cost | Not Applicable |
| | **Preferred 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 Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $115 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $275 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 | $15 Copay |
| | | Tier 2 (Generic) | Not Applicable | $57 Copay |
| | | Tier 3 (Preferred Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $141 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs. | | | |
| | Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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 Select

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| | | | | |
|---|---|---|---|---|
| **Deductible** | $0 | | | |
| **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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $45 Copay | $135 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $47 Copay | $141 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | $100 Copay | $300 Copay |
| | | Tier 5 (Specialty Tier) | 33% of the cost | Not Applicable |
| | **Preferred 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 Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $115 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $275 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 | $15 Copay |
| | | Tier 2 (Generic) | Not Applicable | $57 Copay |
| | | Tier 3 (Preferred Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $141 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs. | | | |
| | Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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 Classic

DRUG

You pay the following until your total yearly drug costs reach $4,660.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

| | | | | |
|---|---|---|---|---|
| **Deductible** | $0 | | | |
| **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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $45 Copay | $135 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 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 Insulin) | $35 Copay | $105 Copay |
| | | Tier 3 (Preferred Brand) | $47 Copay | $141 Copay |
| | | Tier 4 (Insulin) | $35 Copay | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | $100 Copay | $300 Copay |
| | | Tier 5 (Specialty Tier) | 33% of the cost | Not Applicable |
| | **Preferred 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 Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $115 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $275 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 | $15 Copay |
| | | Tier 2 (Generic) | Not Applicable | $57 Copay |
| | | Tier 3 (Preferred Insulin) | Not Applicable | $105 Copay |
| | | Tier 3 (Preferred Brand) | Not Applicable | $141 Copay |
| | | Tier 4 (Insulin) | Not Applicable | $105 Copay |
| | | Tier 4 (Non-Preferred Drug) | Not Applicable | $300 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 Copay for generics and a $10.35 Copay for all other drugs. | | | |
| | Greater of: 5% or $4.15 Generic / Preferred Multi-Source or $10.35 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 Classic | | | |
|---|---|---|---|
| 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.