HIGHMARK
NORTHEASTERN NEW YORK

Northeastern New York

Freedom Value (HMO)

Summary of Benefits

January 1, 2023 to December 31, 2023

The service area for these plans includes the following counties:

Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington

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 Value (HMO), call 1-855-856-8348 (TTY users call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday or visit medicare.highmark.com.

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Northeastern New York

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 Value (HMO) 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.

	Freedom Value (HMO)
Premium	$0.00
Part B Premium Reduction	$2.00
Deductible	$0
Max Out-Of-Pocket	$7,550
Inpatient Hospital Stay*	Days 1 - 5: $375 copay per day per admit & Days 6 - 90: $0 copay per admit $1,875 OOP Max per year
Outpatient Hospital Coverage*	ASC[1]: $275 copay Facility: $375 copay
Doctor Office Visit	PCP: $0 copay Specialist: $41 copay
Preventive/Screening	Covered in Full (Office visit copay may apply)
Emergency Room	$95 copay
Urgently Needed Services	$60 copay
Lab & Diagnostic Tests*	Office/Lab: $10 copay Outpatient: $10 copay Lab: $10 copay Diagnostic: IN: $50 copay
X-Rays* / Advanced Imaging*	X-ray: $50 copay Advanced Imaging: $200 copay
Hearing Services	Medicare Covered: $41 copay. Routine: $45 copay (1 Per Year). (2 Aids Every Year) TruHearing Advanced: $699 copay; TruHearing Premium: $999 copay
Dental Services	Medicare Covered: $41 copay. Office Visit: $0 copay (1 per six months). Office visit includes a cleaning. X-Rays: $0 copay (1 per year). Comprehensive (for all other Class I and Class II Services): 50% coinsurance with a maximum $2,000 allowance (Per Year).
Vision Services	Medicare Covered: $41 copay. Routine: $25 copay (1 per year). $0 copay for eyeglasses or contact lenses after cataract surgery. $100 annual eyewear allowance.
Mental Health Services*	Inpatient: Days 1 - 6: $310 copay per day per admit & Days 7 - 90: $0 copay per day per admit; $1,860 OOP Max per year; Outpatient: $40 copay
Skilled Nursing Facility*	$0 copay/day (days 1-20), $196 copay/day (days 21-100)
Physical Therapy*	$30 copay
Ambulance (per one-way trip)	Emergent: $290 copay
Transportation	Not covered
Part B Drugs*†	20% coinsurance
OTC	$25 allowance once per quarter
Routine Podiatry	$41 copay (3 visits per year)
Durable Medical Equipment*	20% coinsurance $0 copay for compression stockings
Fitness Benefit	Covered in full
Formulary	Fundamental

*Indicates a service that requires prior authorization.

†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 Value (HMO)

DRUG

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

Deductible	$295 on Tiers 3, 4 and 5			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$3 Copay	$9 Copay
		Tier 2 (Generic)	$10 Copay	$30 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$94 Copay	$282 Copay
		Tier 5 (Specialty Tier)	28% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$8 Copay	$24 Copay
		Tier 2 (Generic)	$15 Copay	$45 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)	28% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$3 Copay	$0 Copay
		Tier 2 (Generic)	$10 Copay	$25 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$105 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$94 Copay	$235 Copay
		Tier 5 (Specialty Tier)	28% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**90 Day Supply**
		Tier 1 (Preferred Generic)	$8 Copay	$20.00 Copay
		Tier 2 (Generic)	$15 Copay	$37.50 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$117.50 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$250 Copay
		Tier 5 (Specialty Tier)	28% 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 Generic/Preferred Multi-Source or $10.35 Copay for all other drugs.			

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

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NORTHEASTERN NEW YORK

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Highmark Blue Shield of Northeastern New York is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark Blue Shield of Northeastern New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information is not a complete description of benefits. Call 1-855-856-8348 (TTY users may call 711) for more information.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered trademark of Tivity Health, Inc. Tivity Health, Inc., is a separate company that administers the SilverSneakers program.