HIGHMARK.
Freedom Blue PPO

Freedom Blue℠ PPO

2013 Summary of Benefits

CENTRAL AND
NORTHEASTERN PENNSYLVANIA

H3916_12_0304 File & Use
Contract Number H3916

January 1, 2013 through December 31, 2013

Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO)
January 1, 2013 – December 31, 2013
CENTRAL AND NORTHEASTERN PENNSYLVANIA

Thank you for your interest in Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO). Our plan is offered by Highmark Inc., a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE
As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. You may be able to join or leave a plan only at certain times. Please call Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?
You can compare Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE ARE FREEDOM BLUE PPO VALUE (PPO), HD RX (PPO), VALUERX (PPO), STANDARD (PPO) AND DELUXE (PPO) AVAILABLE?
The service area for this plan includes: 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 Counties, PA. You must live in one of these areas to join the plan. There is more than one plan listed in this Summary of Benefits.

WHO IS ELIGIBLE TO JOIN FREEDOM BLUE PPO VALUE (PPO), HD RX (PPO), VALUERX (PPO), STANDARD (PPO) OR DELUXE (PPO)?
You can join Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?
Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at www.highmarkblueshield.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?
You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?
Freedom Blue PPO HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.highmarkblueshield.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?
Freedom Blue PPO Value (PPO) does cover Medicare Part B prescription drugs. Freedom Blue PPO Value (PPO) does NOT cover Medicare Part D prescription drugs.

Freedom Blue PPO HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?
Freedom Blue PPO HD Rx (PPO), ValueRx (PPO), Standard (PPO) and Deluxe (PPO) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://client.formularynavigator.com/clients/highmark/default.html. If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?
You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:
- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?
All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare

HIGHMARK®
Freedom Blue PPO

For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Freedom Blue PPO HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Freedom Blue PPO HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable osteoporosis drugs for some women.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Highmark Inc. for more information about Freedom Blue PPO Value (PPO), HD Rx (PPO), ValueRx (PPO), Standard (PPO) or Deluxe (PPO).

Visit us at www.highmarkblueshield.com or, call us:

Customer Service Hours for October 1- February 14:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Customer Service Hours for February 15 - September 30:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (800)-550-8722 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (888)-422-1226)

Prospective members should call toll-free (866)-682-7971 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (800)-227-8210)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

HIGHMARK®
Freedom Blue PPO

**For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971,
(TTY/TDD users 800-227-8210).**

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
IMPORTANT INFORMATION						
1 - Premium and Other Important Information	In 2012 the monthly Part B Premium was $99.90 and may change for 2013 and the annual Part B deductible amount was $140 and may change for 2013. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $81 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800 -633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877 -486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of -network) accept "assignment" from Medicare and will only charge up to a Medicare -approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-	**General** $60 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877 -486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of -network) accept "assignment" from Medicare and will only charge up to a Medicare -approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-	**General** $165 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877 -486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of -network) accept "assignment" from Medicare and will only charge up to a Medicare -approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-	**General** $208 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877 -486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of -network) accept "assignment" from Medicare and will only charge up to a Medicare -approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
IMPORTANT INFORMATION						
1 - Premium and Other Important Information *(continued)*		of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.	of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. Highmark Inc. will reduce your monthly Medicare Part B premium by up to $ 3.00. **In-Network** $5,000 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $950 annual deductible. Contact the plan for services that apply. Any annual service category deductible may count towards the plan level deductible, if there is one. $10,000 out-of-pocket limit for Medicare-covered services.	of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.	of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.	of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
IMPORTANT INFORMATION						
2 - Doctor and Hospital Choice *(For more information, see Emergency Care -#15 and Urgently Needed Care - #16.)*	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S. or its territories.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S. or its territories.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S. or its territories.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S. or its territories.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S. or its territories.
SUMMARY OF BENEFITS						
INPATIENT CARE						
3 - Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	In 2012 the amounts for each benefit period were: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day These amounts may change for 2013. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a	**In-Network** No limit to the number of days covered by the plan each hospital stay. $350 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $1,400 out-of-pocket limit every stay. 10% of the cost for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1 - 5: $200 copay per day Days 6 - 90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $150 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
INPATIENT CARE						
3 - Inpatient Hospital Care *(continued)*	new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.					
4 - Inpatient Mental Health Care	In 2012 the amounts for each benefit period were: Days 1 - 60: $1156 deductible Days 61 - 90: $289 per day Days 91 - 150: $578 per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $350 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. The out-of-pocket limit is covered under "Inpatient Hospital Care." 10% of the cost for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1 - 5: $200 copay per day Days 6 - 90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $300 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $150 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
INPATIENT CARE						
5 - Skilled Nursing Facility (SNF) *(in a Medicare-certified skilled nursing facility)*	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $144.50 per day These amounts may change for 2013. 100 days for each benefit period. A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 5: $0 copay per day Days 6 - 20: $50 copay per day Days 21 - 100: $100 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 5: $0 copay per day Days 6 - 20: $50 copay per day Days 21 - 100: $100 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 5: $0 copay per day Days 6 - 20: $50 copay per day Days 21 - 100: $100 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 5: $0 copay per day Days 6 - 20: $40 copay per day Days 21 - 100: $75 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 5: $0 copay per day Days 6 - 20: $25 copay per day Days 21 - 100: $50 copay per day **Out-of-Network** 30% of the cost for each SNF stay.
6 - Home Health Care *(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)*	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for Medicare-covered home health visits

For questions about this plan’s benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
INPATIENT CARE						
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE						
8 - Doctor Office Visits	20% coinsurance	**In-Network** $20 copay for each Medicare-covered primary care doctor visit. $35 copay for each Medicare-covered specialist visit. **Out-of-Network** $30 copay for each Medicare-covered primary care doctor visit $45 copay for each Medicare-covered specialist visit	**In-Network** $5 copay for each Medicare-covered primary care doctor visit. $15 copay for each Medicare-covered specialist visit. **Out-of-Network** 30% of the cost for each Medicare-covered primary care doctor visit 30% of the cost for each Medicare-covered specialist visit	**In-Network** $15 copay for each Medicare-covered primary care doctor visit. $40 copay for each Medicare-covered specialist visit. **Out-of-Network** $30 copay for each Medicare-covered primary care doctor visit $50 copay for each Medicare-covered specialist visit	**In-Network** $15 copay for each Medicare-covered primary care doctor visit. $35 copay for each Medicare-covered specialist visit. **Out-of-Network** $30 copay for each Medicare-covered primary care doctor visit $45 copay for each Medicare-covered specialist visit	**In-Network** $10 copay for each Medicare-covered primary care doctor visit. $30 copay for each Medicare-covered specialist visit. **Out-of-Network** $30 copay for each Medicare-covered primary care doctor visit $40 copay for each Medicare-covered specialist visit
9 - Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit $20 copay for up to 8 supplemental routine chiropractic visit(s) every year Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. **Out-of-Network** 30% of the cost for Medicare-covered chiropractic visits.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. **Out-of-Network** 30% of the cost for Medicare-covered chiropractic visits.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit $20 copay for up to 8 supplemental routine chiropractic visit(s) every year Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. **Out-of-Network** 30% of the cost for Medicare-covered chiropractic visits.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit $20 copay for up to 8 supplemental routine chiropractic visit(s) every year Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. **Out-of-Network** 30% of the cost for Medicare-covered chiropractic visits.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered chiropractic visit $20 copay for up to 8 supplemental routine chiropractic visit(s) every year Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor. **Out-of-Network** 30% of the cost for Medicare-covered chiropractic visits.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT CARE						
9 - Chiropractic Services *(continued)*		30% of the cost for supplemental routine chiropractic visits.		30% of the cost for supplemental routine chiropractic visits.	30% of the cost for supplemental routine chiropractic visits.	30% of the cost for supplemental routine chiropractic visits.
10 - Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $35 copay for each Medicare-covered podiatry visit $35 copay for up to 10 supplemental routine podiatry visit(s) every year Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for Medicare-covered podiatry visits 30% of the cost for supplemental routine podiatry visits	**In-Network** 10% of the cost for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for Medicare-covered podiatry visits	**In-Network** $40 copay for each Medicare-covered podiatry visit $40 copay for up to 10 supplemental routine podiatry visit(s) every year Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for Medicare-covered podiatry visits 30% of the cost for supplemental routine podiatry visits	**In-Network** $35 copay for each Medicare-covered podiatry visit $35 copay for up to 10 supplemental routine podiatry visit(s) every year Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for Medicare-covered podiatry visits 30% of the cost for supplemental routine podiatry visits	**In-Network** $30 copay for each Medicare-covered podiatry visit $30 copay for up to 10 supplemental routine podiatry visit(s) every year Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for Medicare-covered podiatry visits 30% of the cost for supplemental routine podiatry visits
11-Outpatient Mental Health Care	35% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient	**General** Authorization rules may apply. **In-Network** $35 copay for each Medicare-covered individual therapy visit $35 copay for each Medicare-covered group therapy visit $35 copay for each Medicare-covered individual therapy visit with a psychiatrist $35 copay for each Medicare-covered group therapy visit with a psychiatrist	**General** Authorization rules may apply. **In-Network** 10% of the cost for each Medicare-covered individual therapy visit 10% of the cost for each Medicare-covered group therapy visit $15 copay for each Medicare-covered individual therapy visit with a psychiatrist $15 copay for each Medicare-covered group therapy visit with a psychiatrist	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual therapy visit $40 copay for each Medicare-covered group therapy visit $40 copay for each Medicare-covered individual therapy visit with a psychiatrist $40 copay for each Medicare-covered group therapy visit with a psychiatrist	**General** Authorization rules may apply. **In-Network** $35 copay for each Medicare-covered individual therapy visit $35 copay for each Medicare-covered group therapy visit $35 copay for each Medicare-covered individual therapy visit with a psychiatrist $35 copay for each Medicare-covered group therapy visit with a psychiatrist	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT CARE						
11-Outpatient Mental Health Care *(continued)*	hospitalization.	$0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Medicare-covered Mental Health visits with a psychiatrist 30% of the cost for Medicare-covered Mental Health visits 30% of the cost for Medicare-covered partial hospitalization program services	15% of the cost for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Medicare-covered Mental Health visits with a psychiatrist 30% of the cost for Medicare-covered Mental Health visits 30% of the cost for Medicare-covered partial hospitalization program services	$0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Medicare-covered Mental Health visits with a psychiatrist 30% of the cost for Medicare-covered Mental Health visits 30% of the cost for Medicare-covered partial hospitalization program services	$0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Medicare-covered Mental Health visits with a psychiatrist 30% of the cost for Medicare-covered Mental Health visits 30% of the cost for Medicare-covered partial hospitalization program services	$0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Medicare-covered Mental Health visits with a psychiatrist 30% of the cost for Medicare-covered Mental Health visits 30% of the cost for Medicare-covered partial hospitalization program services
12 - Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered individual substance abuse outpatient treatment visits $35 copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** 30% of the cost for Medicare-covered substance abuse outpatient treatment visits	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered individual substance abuse outpatient treatment visits 10% of the cost for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** 30% of the cost for Medicare-covered substance abuse outpatient treatment visits	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual substance abuse outpatient treatment visits $40 copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** 30% of the cost for Medicare-covered substance abuse outpatient treatment visits	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered individual substance abuse outpatient treatment visits $35 copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** 30% of the cost for Medicare-covered substance abuse outpatient treatment visits	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered individual substance abuse outpatient treatment visits $30 copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** 30% of the cost for Medicare-covered substance abuse outpatient treatment visits
13 - Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center	**General** Authorization rules may apply. **In-Network** $200 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** 15% of the cost for each Medicare-covered ambulatory surgical center visit 15% of the cost for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** $300 copay for each Medicare-covered ambulatory surgical center visit $300 copay for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** $200 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit $150 copay for each Medicare-covered outpatient hospital facility visit

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT CARE						
13 - Outpatient Services *(continued)*	facility services	**Out-of-Network** 30% of the cost for Medicare-covered outpatient hospital facility visits 30% of the cost for Medicare-covered ambulatory surgical center visits	**Out-of-Network** 30% of the cost for Medicare-covered outpatient hospital facility visits 30% of the cost for Medicare-covered ambulatory surgical center visits	**Out-of-Network** 30% of the cost for Medicare-covered outpatient hospital facility visits 30% of the cost for Medicare-covered ambulatory surgical center visits	**Out-of-Network** 30% of the cost for Medicare-covered outpatient hospital facility visits 30% of the cost for Medicare-covered ambulatory surgical center visits	**Out-of-Network** 30% of the cost for Medicare-covered outpatient hospital facility visits 30% of the cost for Medicare-covered ambulatory surgical center visits
14 - Ambulance Services *(medically necessary ambulance services)*	20% coinsurance	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 30% of the cost] for Medicare-covered ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 30% of the cost] for Medicare-covered ambulance benefits.	**In-Network** $125 copay for Medicare-covered ambulance benefits. **Out-of-Network** $125 copay [or 30% of the cost] for Medicare-covered ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 30% of the cost] for Medicare-covered ambulance benefits.	**In-Network** $75 copay for Medicare-covered ambulance benefits. **Out-of-Network** $75 copay [or 30% of the cost] for Medicare-covered ambulance benefits.
15 - Emergency Care *(You may go to any emergency room if you reasonably believe you need emergency care.)*	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)
OUTPATIENT CARE			
16 - Urgently Needed Care *(This is NOT emergency care, and in most cases, is out of the service area.)*	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits
17 - Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	20% coinsurance	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered Occupational Therapy visits $35 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** 30% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 30% of the cost for Medicare-covered Occupational Therapy visits.	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered Occupational Therapy visits 10% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** 30% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 30% of the cost for Medicare-covered Occupational Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment *(includes wheelchairs, oxygen, etc.)*	20% coinsurance	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment **Out-of-Network** 0% to 50% of the cost for	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered durable medical equipment **Out-of-Network** 0% to 50% of the cost for

FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
General $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits
General Authorization rules may apply. **In-Network** $40 copay for Medicare-covered Occupational Therapy visits $40 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** 30% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 30% of the cost for Medicare-covered Occupational Therapy visits.	**General** Authorization rules may apply. **In-Network** $35 copay for Medicare-covered Occupational Therapy visits $35 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** 30% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 30% of the cost for Medicare-covered Occupational Therapy visits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered Occupational Therapy visits $30 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** 30% of the cost for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits 30% of the cost for Medicare-covered Occupational Therapy visits.
General Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment **Out-of-Network** 0% to 50% of the cost for	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment **Out-of-Network** 0% to 50% of the cost for	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered durable medical equipment **Out-of-Network** 0% to 50% of the cost for

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
18 - Durable Medical Equipment *(continued)*		Medicare-covered durable medical equipment	Medicare-covered durable medical equipment	Medicare-covered durable medical equipment	Medicare-covered durable medical equipment	Medicare-covered durable medical equipment
19 - Prosthetic Devices *(includes braces, artificial limbs and eyes, etc.)*	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices **Out-of-Network** 50% of the cost for Medicare-covered prosthetic devices.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered prosthetic devices **Out-of-Network** 50% of the cost for Medicare-covered prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices **Out-of-Network** 50% of the cost for Medicare-covered prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices **Out-of-Network** 50% of the cost for Medicare-covered prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices **Out-of-Network** 50% of the cost for Medicare-covered prosthetic devices.
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $20 to $35 may apply **Out-of-Network** 0% of the cost for Medicare-covered Diabetes self-management training 50% of the cost for Medicare-covered Diabetes monitoring supplies	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training $0 copay for Medicare-covered: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $5 to $15 may apply **Out-of-Network** 0% of the cost for Medicare-covered Diabetes self-management training 50% of the cost for Medicare-covered Diabetes monitoring supplies	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $15 to $40 may apply **Out-of-Network** 0% of the cost for Medicare-covered Diabetes self-management training 50% of the cost for Medicare-covered Diabetes monitoring supplies	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $15 to $35 may apply **Out-of-Network** 0% of the cost for Medicare-covered Diabetes self-management training 50% of the cost for Medicare-covered Diabetes monitoring supplies	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered Diabetes self-management training 0% to 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $30 may apply **Out-of-Network** 0% of the cost for Medicare-covered Diabetes self-management training 50% of the cost for Medicare-covered Diabetes monitoring supplies

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
20 - Diabetes Programs and Supplies *(continued)*		50% of the cost for Medicare-covered Therapeutic shoes or inserts	50% of the cost for Medicare-covered Therapeutic shoes or inserts	50% of the cost for Medicare-covered Therapeutic shoes or inserts	50% of the cost for Medicare-covered Therapeutic shoes or inserts	50% of the cost for Medicare-covered Therapeutic shoes or inserts
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • therapeutic radiology services $0 to $30 copay for Medicare-covered lab services $0 to $30 copay for Medicare-covered diagnostic procedures and tests $30 copay for Medicare-covered X-rays $125 copay for Medicare-covered diagnostic radiology services (not including X-rays) If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $20 to $35 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $20 to $35 may apply **Out-of-Network** 0% to 30% of the cost for Medicare-covered diagnostic procedures, tests, and lab	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • therapeutic radiology services 0% to 10% of the cost for Medicare-covered lab services 0% to 10% of the cost for Medicare-covered diagnostic procedures and tests 10% of the cost for Medicare-covered X-rays 15% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $5 to $15 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $5 to $15 may apply **Out-of-Network** 0% to 30% of the cost for Medicare-covered diagnostic procedures, tests, and lab	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • therapeutic radiology services $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $30 copay for Medicare-covered X-rays $150 copay for Medicare-covered diagnostic radiology services (not including X-rays) If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $15 to $40 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $15 to $40 may apply **Out-of-Network** 0% to 30% of the cost for Medicare-covered diagnostic procedures, tests, and lab	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • therapeutic radiology services $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $20 copay for Medicare-covered X-rays $75 copay for Medicare-covered diagnostic radiology services (not including X-rays) If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $15 to $35 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $15 to $35 may apply **Out-of-Network** 0% to 30% of the cost for Medicare-covered diagnostic procedures, tests, and lab	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • therapeutic radiology services $10 copay for Medicare-covered X-rays $50 copay for Medicare-covered diagnostic radiology services (not including X-rays) If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $30 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $30 may apply **Out-of-Network** 0% to 30% of the cost for Medicare-covered diagnostic procedures, tests, and lab

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services *(continued)*		services 30% of the cost for Medicare-covered therapeutic radiology services 30% of the cost for Medicare-covered outpatient X-rays 30% of the cost for Medicare-covered diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of $30 to $45 may apply	services 30% of the cost for Medicare-covered therapeutic radiology services 30% of the cost for Medicare-covered outpatient X-rays 30% of the cost for Medicare-covered diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 30% of the cost may apply	services 30% of the cost for Medicare-covered therapeutic radiology services 30% of the cost for Medicare-covered outpatient X-rays 30% of the cost for Medicare-covered diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of $30 to $50 may apply	services 30% of the cost for Medicare-covered therapeutic radiology services 30% of the cost for Medicare-covered outpatient X-rays 30% of the cost for Medicare-covered diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of $30 to $45 may apply	services 30% of the cost for Medicare-covered therapeutic radiology services 30% of the cost for Medicare-covered outpatient X-rays 30% of the cost for Medicare-covered diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of $30 to $40 may apply
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Medicare-covered Cardiac Rehabilitation Services 30% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Medicare-covered Cardiac Rehabilitation Services 30% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Medicare-covered Cardiac Rehabilitation Services 30% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Medicare-covered Cardiac Rehabilitation Services 30% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Medicare-covered Cardiac Rehabilitation Services 30% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
22 - Cardiac and Pulmonary Rehabilitation Services *(continued)*		30% of the cost for Medicare-covered Pulmonary Rehabilitation Services	30% of the cost for Medicare-covered Pulmonary Rehabilitation Services	30% of the cost for Medicare-covered Pulmonary Rehabilitation Services	30% of the cost for Medicare-covered Pulmonary Rehabilitation Services	30% of the cost for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS						
23 -Preventive Services, Wellness/ Education and other Supplemental Benefit Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/ wellness programs: • Health Club Membership/ Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/ wellness programs	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/ wellness programs: • Health Club Membership/ Fitness Classes **Out-of-Network** 50% of the cost for supplemental education/ wellness programs 0% of the cost for Medicare-covered preventive services	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/ wellness programs: • Health Club Membership/ Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/ wellness programs	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/ wellness programs: • Health Club Membership/ Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/ wellness programs	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/ wellness programs: • Health Club Membership/ Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/ wellness programs

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS						
23 -Preventive Services, Wellness/ Education and other Supplemental Benefit Programs *(continued)*	covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening					

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS						
23 -Preventive Services, Wellness/ Education and other Supplemental Benefit Programs *(continued)*	• Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity • Welcome to Medicare Preventive Visits (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits					

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PREVENTIVE SERVICES, WELLNESS/ EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS						
23 -Preventive Services, *(continued)*	or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.					
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** 0% of the cost for Medicare-covered kidney disease education services 0% to 30% of the cost for Medicare-covered renal dialysis	**In-Network** 15% of the cost for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** 0% of the cost for Medicare-covered kidney disease education services 0% to 30% of the cost for Medicare-covered renal dialysis	**In-Network** $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** 0% of the cost for Medicare-covered kidney disease education services 0% to 30% of the cost for Medicare-covered renal dialysis	**In-Network** $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** 0% of the cost for Medicare-covered kidney disease education services 0% to 30% of the cost for Medicare-covered renal dialysis	**In-Network** $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** 0% of the cost for Medicare-covered kidney disease education services 0% to 30% of the cost for Medicare-covered renal dialysis
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** Most drugs not covered. 0% to 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 30% of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** This plan does not offer prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 0% to 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 30% of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the	**Drugs covered under Medicare Part B** **General** 0% to 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 30% of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the	**Drugs covered under Medicare Part B** **General** 0% to 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 30% of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the	**Drugs covered under Medicare Part B** **General** 0% to 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 30% of the cost for Medicare Part B drugs out-of-network. **Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs *(continued)*			formulary. You can also see the formulary at http://client.formularynavigator.com/clients/highmark/default.html on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/ Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue PPO HD Rx (PPO) for certain drugs. You must go to certain pharmacies for a very limited	formulary. You can also see the formulary at http://client.formularynavigator.com/clients/highmark/default.html on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/ Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue PPO ValueRx (PPO) for certain drugs. You must go to certain pharmacies for a very limited	formulary. You can also see the formulary at http://client.formularynavigator.com/clients/highmark/default.html on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/ Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue PPO Standard (PPO) for certain drugs. You must go to certain pharmacies for a very limited	formulary. You can also see the formulary at http://client.formularynavigator.com/clients/highmark/default.html on the web. Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to Indian/ Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue PPO Deluxe (PPO) for certain drugs. You must go to certain pharmacies for a very limited

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)
PRESCRIPTION DRUG BENEFITS			
25 - Outpatient Prescription Drugs *(continued)*			number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue PPO HD Rx (PPO) approves the exception, you will pay Tier 2: Preferred Brand cost sharing for that drug **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,970: **Retail Pharmacy** **Tier 1: Generic** • $10 copay for a one-month (34-day) supply of drugs in this tier • $30 copay for a three-month (90-day) supply of drugs in this tier

FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue PPO ValueRx (PPO) approves the exception, you will pay Tier 2: Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,970: **Retail Pharmacy** **Tier 1: Generic** • $10 copay for a one-month (34-day) supply of drugs in this tier • $30 copay for a three-month (90-day) supply of drugs in this tier	number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue PPO Standard (PPO) approves the exception, you will pay Tier 2: Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,970: **Retail Pharmacy** **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier	number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue PPO Deluxe (PPO) approves the exception, you will pay Tier 2: Preferred Brand cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,970: **Retail Pharmacy** **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs *(continued)*			**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier • $135 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of drugs in this tier • $285 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy Tier 1: Generic** • $10 copay for a one-month (34-day) supply of generic drugs in this tier **Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-	**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier • $135 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of drugs in this tier • $285 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy Tier 1: Generic** • $10 copay for a one-month (34-day) supply of generic drugs in this tier **Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-	**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier • $135 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of drugs in this tier • $270 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy Tier 1: Generic** • $8 copay for a one-month (34-day) supply of generic drugs in this tier **Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-	**Tier 2: Preferred Brand** • $42 copay for a one-month (34-day) supply of drugs in this tier • $126 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of drugs in this tier • $270 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Long Term Care Pharmacy Tier 1: Generic** • $8 copay for a one-month (34-day) supply of generic drugs in this tier **Tier 2: Preferred Brand** • $42 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of brand drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)
PRESCRIPTION DRUG BENEFITS			
25 - Outpatient Prescription Drugs *(continued)*			month (34-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Generic** • $25 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** • $112.50 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $237.50 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% of the plan's costs for brand drugs and 79% of the plan's costs for

FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
month (34-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Generic** • $25 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** • $112.50 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $237.50 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% of the plan's costs for brand drugs and 79% of the plan's costs for	month (34-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Generic** • $20 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** • $112.50 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $225 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% of the plan's costs for brand drugs and 79% of the plan's costs for	month (34-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. **Mail Order** **Tier 1: Generic** • $20 copay for a three-month (90-day) supply of drugs in this tier **Tier 2: Preferred Brand** • $105 copay for a three-month (90-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $225 copay for a three-month (90-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a three-month (90-day) supply of drugs in this tier **Coverage Gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% of the plan's costs for brand drugs and 79% of the plan's costs for

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)
PRESCRIPTION DRUG BENEFITS			
25 - Outpatient Prescription Drugs *(continued)*			generic drugs until your yearly out-of-pocket drug costs reach $4,750.

FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
generic drugs until your yearly out-of-pocket drug costs reach $4,750.	generic drugs until your yearly out-of-pocket drug costs reach $4,750.	generic drugs until your yearly out-of-pocket drug costs reach $4,750. **Additional Coverage Gap** The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: **Retail Pharmacy** **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of all drugs covered in this tier • $24 copay for a three-month (90-day) supply of all drugs covered in this tier **Long Term Care Pharmacy** **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of all generic drugs covered in this tier **Mail Order** **Tier 1: Generic** • $20 copay for a three-month (90-day) supply of all drugs covered in this tier

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs *(continued)*			**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue PPO HD Rx (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: **Tier 1: Generic** • $10 copay for a one-month (34-day) supply of drugs in this tier	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue PPO ValueRx (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: **Tier 1: Generic** • $10 copay for a one-month (34-day) supply of drugs in this tier	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue PPO Standard (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue PPO Deluxe (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970: **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs *(continued)*			**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Tier 2: Preferred Brand** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Tier 2: Preferred Brand** • $42 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
PRESCRIPTION DRUG BENEFITS						
25 - Outpatient Prescription Drugs *(continued)*			**Additional Out-of-Network Coverage Gap** You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Additional Out-of-Network Coverage Gap** You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Additional Out-of-Network Coverage Gap** You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Additional Out-of-Network Coverage Gap** The plan covers many formulary generics (65% to 99% of formulary generic drugs) through the coverage gap. You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Generic** • $8 copay for a one-month (34-day) supply of all drugs covered in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
			Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $35 to $200 copay for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for Medicare-covered comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. 15% of the cost for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for Medicare-covered comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $40 to $300 copay for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for Medicare-covered comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $35 to $200 copay for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for Medicare-covered comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** $30 to $150 copay for Medicare-covered dental benefits • 30% of the cost for up to 1 oral exam(s) every six months • 30% of the cost for up to 1 cleaning(s) every six months • 30% of the cost for up to 1 dental x-ray(s) every year **Out-of-Network** 50% of the cost for supplemental preventive dental benefits 30% to 50% of the cost for Medicare-covered comprehensive dental benefits 30% to 50% of the cost for supplemental comprehensive dental benefits **In and Out-of-Network** Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for hearing aids. $35 copay for Medicare-covered diagnostic hearing exams	**In-Network** $0 copay for hearing aids. $15 copay for Medicare-covered diagnostic hearing exams	**In-Network** $0 copay for hearing aids. $40 copay for Medicare-covered diagnostic hearing exams	**In-Network** $0 copay for hearing aids. $35 copay for Medicare-covered diagnostic hearing exams	**In-Network** $0 copay for hearing aids. $30 copay for Medicare-covered diagnostic hearing exams

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
27 - Hearing Services *(continued)*		$35 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for Medicare-covered diagnostic hearing exams. 30% of the cost for supplemental hearing exams. 0% of the cost for supplemental hearing aids. The plan will pay up to $500 for all of the following services combined: Supplemental • Hearing Aids **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	$15 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for Medicare-covered diagnostic hearing exams. 30% of the cost for supplemental hearing exams. 0% of the cost for supplemental hearing aids. The plan will pay up to $500 for all of the following services combined: Supplemental • Hearing Aids **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	$40 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for Medicare-covered diagnostic hearing exams. 30% of the cost for supplemental hearing exams. 0% of the cost for supplemental hearing aids. The plan will pay up to $500 for all of the following services combined: Supplemental • Hearing Aids **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	$35 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for Medicare-covered diagnostic hearing exams. 30% of the cost for supplemental hearing exams. 0% of the cost for supplemental hearing aids. The plan will pay up to $500 for all of the following services combined: Supplemental • Hearing Aids **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	$30 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for Medicare-covered diagnostic hearing exams. 30% of the cost for supplemental hearing exams. 0% of the cost for supplemental hearing aids. The plan will pay up to $1,000 for all of the following services combined: Supplemental • Hearing Aids **In and Out-of-Network** $1,000 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)	FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES						
28 - Vision Services *(continued)*		• $0 to $35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $35 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $20 to $35 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for Medicare-covered eye exams 0% to 30% of the cost for supplemental eye exams 30% of the cost for Medicare-covered eye wear 30% of the cost for supplemental eye wear **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits.	• $0 to $15 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $15 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $5 to $15 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for Medicare-covered eye exams 0% to 30% of the cost for supplemental eye exams 30% of the cost for Medicare-covered eye wear 30% of the cost for supplemental eye wear **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits.	• $0 to $40 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $40 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $15 to $40 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for Medicare-covered eye exams 0% to 30% of the cost for supplemental eye exams 30% of the cost for Medicare-covered eye wear 30% of the cost for supplemental eye wear **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits.	• $0 to $35 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $35 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $15 to $35 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for Medicare-covered eye exams 0% to 30% of the cost for supplemental eye exams 30% of the cost for Medicare-covered eye wear 30% of the cost for supplemental eye wear **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits.	• $0 to $30 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $30 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $10 to $30 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for Medicare-covered eye exams 0% to 30% of the cost for supplemental eye exams 30% of the cost for Medicare-covered eye wear 30% of the cost for supplemental eye wear **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOM BLUE PPO VALUE (PPO)	FREEDOM BLUE HD RX (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
28 - Vision Services *(continued)*		$100 plan coverage limit for eye glass frames every two years.This limit applies to both in-network and out-of-network benefits.	$100 plan coverage limit for eye glass frames every two years.This limit applies to both in-network and out-of-network benefits.
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

FREEDOM BLUE PPO VALUERX (PPO)	FREEDOM BLUE PPO STANDARD (PPO)	FREEDOM BLUE PPO DELUXE (PPO)
$100 plan coverage limit for eye glass frames every two years.This limit applies to both in-network and out-of-network benefits.	$100 plan coverage limit for eye glass frames every two years.This limit applies to both in-network and out-of-network benefits.	$100 plan coverage limit for eye glass frames every two years.This limit applies to both in-network and out-of-network benefits.
General The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
In-Network $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.
In-Network This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

For questions about this plan's benefits or costs, please contact Highmark, Inc. Current Members call (800)-550-8722, (TTY/TDD users (888)-422-1226) and prospective members call (866)-682-7971, (TTY/TDD users 800-227-8210).

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-456-3738. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-456-3738. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-456-3738。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-456-3738。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-456-3738. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-456-3738. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-456-3738 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-456-3738. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-456-3738 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-456-3738. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه مترجم فوري، ليس عليك سوى الاتصال بنا على 1-668-654-8373. سيقوم شخص ما يتحدث العربية خدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-456-3738. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-456-3738. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-456-3738. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-456-3738. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-456-3738.पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-456-3738.にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

This page was intentionally left blank

This page was intentionally left blank

Freedom Blue PPO

23116 (R9/12)

1140