This is only a summary of your plan's benefits. See your Evidence of Coverage for more detailed information.

HIGHMARK.

2022 Benefit Summary

The Penn State University

178428

	In Network	Out Of Network
Freedom Blue PPO		
Monthly Plan Premium (per member)[1]		
Deductible	**$0**	
In Network Member Out-of-Pocket Maximum (For Medicare-covered services, not including Part D drugs)	**$500**	**N/A**
Combined In and Out-of-Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)	**$750**	
Annual Physical Exam	**Covered in Full**	**Covered in Full**
Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	**Covered in Full**	**Covered in Full**
Doctor Office Visit	**$10 Copay**	**$10 Copay**
Specialist Office Visit	**$20 Copay**	**$20 Copay**
Advanced Imaging (Examples: CT Scans, MRI)	**0% Coinsurance**	**0% Coinsurance**
Standard Imaging (Examples: X-ray, Mammogram)	**0% Coinsurance**	**0% Coinsurance**
Diagnostic Testing (Example: Blood Work)	**0% Coinsurance**	**0% Coinsurance**
Outpatient Surgery	**0% Coinsurance**	**0% Coinsurance**
Emergency Room Services (Worldwide Coverage)	**$65 Copay**	
Urgently Needed Care	**$40 Copay**	
Inpatient Hospital or Long-Term Acute Care Facility Stay	**0% Coinsurance**	**0% Coinsurance**

[1] **You must continue to pay your Medicare Part B premium**

HEALTH	Skilled Nursing Facility Care (100 days per Medicare benefit period)	0% Coinsurance	0% Coinsurance
	Annual Routine Vision Exam (includes refraction)	Not Covered	Not Covered
	Eyeglasses or Contact Lenses (Covered every year)	Not Covered	Not Covered
	Annual Routine Hearing Exam	$20 Copay	$20 Copay
	Hearing Aids (In-network covered every year)	$499 copay per aid per year for TruHearing Advanced $799 copay per aid per year for TruHearing Premium.	$500 allowance for hearing aids every 3 years.
	Annual Routine Dental Care	Not Covered	Not Covered
	Routine Podiatry Care (10 visits per calendar year)	Not covered	Not covered
	Routine Chiropractic Office Visits (8 visits per year)	Not covered	Not covered
	Home Health	0% Coinsurance	0% Coinsurance
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$20 Copay	$20 Copay
	Renal Dialysis	$0 Copay	10% Coinsurance

[1] You must continue to pay your Medicare Part B premium

Part B Drugs	**0% Coinsurance**	**0% Coinsurance**
Ambulance (Emergent Services per one way trip)	**$100 Copay**	
Ambulance (Non-Emergent per one way trip)	**$100 Copay**	**10% Coinsurance**
Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)	**0% Coinsurance**	**10% Coinsurance**
Oxygen/Oxygen Supplies	**0% Coinsurance**	**10% Coinsurance**
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	**0% Coinsurance**	**0% Coinsurance**
Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	**$20 Copay**	**$20 Copay**

[1] **You must continue to pay your Medicare Part B premium**

PART D DRUGS

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

	Deductible	**$0**	
	Out of Pocket Maximum	**Not applicable**	
Initial Coverage	**Retail Cost Sharing (Preferred Pharmacy)**	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**Not applicable**
		Tier 2 (Generic)	**Not applicable**
		Tier 3 (Preferred Brand)	**Not applicable**
		Tier 4 (Non-Preferred Drugs)	**Not applicable**
		Tier 5 (Specialty)	**Not applicable**
	Retail Cost Sharing (Standard Pharmacy)	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$12.00 Copay**
		Tier 2 (Generic)	**$12.00 Copay**
		Tier 3 (Preferred Brand)	**$20.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$50.00 Copay**
		Tier 5 (Specialty)	**$50.00 Copay**
	Mail Order Cost Sharing	**Tier**	**Up to 90 Day Supply**
		Tier 1 (Preferred Generic)	**$24.00 Copay**
		Tier 2 (Generic)	**$24.00 Copay**
		Tier 3 (Preferred Brand)	**$40.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$100.00 Copay**
		Tier 5 (Specialty)	**$50.00 Copay for a 31 day limit supply**

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.01 until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Coverage Gap	**Retail Cost Sharing (Preferred Pharmacy)**	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**Not applicable**
		Tier 2 (Generic)	**Not applicable**
		Tier 3 (Preferred Brand)	**Not applicable**
		Tier 4 (Non-Preferred Drugs)	**Not applicable**
		Tier 5 (Specialty)	**Not applicable**
	Retail Cost Sharing (Standard Pharmacy)	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$12.00 Copay**
		Tier 2 (Generic)	**$12.00 Copay**
		Tier 3 (Preferred Brand)	**$20.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$50.00 Copay**
		Tier 5 (Specialty)	**$50.00 Copay**

		Tier	Up to 90 Day Supply
	Mail Order Cost Sharing	**Tier 1 (Preferred Generic)**	**$24.00 Copay**
		Tier 2 (Generic)	**$24.00 Copay**
		Tier 3 (Preferred Brand)	**$40.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$100.00 Copay**
		Tier 5 (Specialty)	**$50.00 Copay for a 31 day limit supply**
Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,050.01, you pay the greater of: 5% of the cost or a $3.95 copay for generics and a $9.85 copay for all other drugs.			
Catastrophic Coverage	**the greater of: 5% of the cost or a $3.95 copay for generics and a $9.85 copay for all other drugs.**		

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

Your health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Shield provides post-sale administrative communications for these companies.

Highmark Blue Shield and Highmark Senior Health Company all of which are independent licensees of the Blue Cross and Blue Shield Association.

You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network and provider network may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Highmark Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): 22FB178428

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