2010 FreedomBlue℠ PPO Summary of Benefits

Southwest and West Central Pennsylvania

January 1, 2010 through December 31, 2010

A detailed side-by-side comparison of FreedomBlue PPO plans and Original Medicare.

HIGHMARK. FREEDOMBLUE℠ PPO

A Medicare Advantage PPO

Highmark Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association

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Section One:

Introduction to the Summary of Benefits Report for FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (PPO)

HIGHMARK. FREEDOMBLUE PPO
A Medicare Advantage PPO

January 1, 2010—December 31, 2010

SOUTHWESTERN AND WEST CENTRAL PA

Thank you for your interest in FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (PPO). Our plan is offered by Highmark Inc., a Medicare Advantage Preferred-Provider Organization (PPO). 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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (PPO) available?

The service area for these plans includes the following counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland 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. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call customer service for more information.

Who is eligible to join FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (PPO)?

You can join FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (PPO) unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (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 or for an up-to-date list visit us at www.highmark.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.

Does my plan cover Medicare Part B or Part D drugs?

FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where can I get my prescriptions if I join this plan?

FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (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.highmarkbcbs.com. Our customer service number is listed at the end of this introduction.

What is a prescription drug formulary?

FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) and Platinum (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 enrollees 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://highmark.medicare-approvedformularies.com/.

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 prescription drug plan costs?

You may be able to get extra help for your prescription drug premiums and 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, seven days a week;
- 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 year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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, Quality Insights of Pennsylvania 1-877-346-6180.

As a member of FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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, Quality Insights of Pennsylvania 1-877-346-6180.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we may 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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (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 drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha 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 was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- 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 provided through DME.

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 "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-550-8722 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-988-0668.

Please call Highmark Inc. for more information about FreedomBlue PPO HD Rx (PPO), Select (PPO), Classic (PPO) or Platinum (PPO).

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

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

Current members should call toll free 1-800-550-8722 for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-988-0668)

Prospective members should call toll free 1-800-350-1973 for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-862-0709)

Current members should call locally 1-800-550-8722 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-988-0668)

Prospective members should call locally 1-800-350-1973 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-862-0709)

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.

If you have special needs, this document may be available in other formats.

HIGHMARK.
FREEDOMBLUE PPO
A Medicare Advantage PPO

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
IMPORTANT INFORMATION					
1 - Premium and Other Important Information	In 2009 the monthly Part B Premium was $96.40 and will change for 2010 and the yearly Part B deductible amount was $135 and will change for 2010. 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, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was $85,000 for singles, $170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	General Premiums range from $0 to $0 in addition to your monthly Medicare Part B premium. Please refer to the premium table located after this section to find out what the premium is in your area. In and Out-of-Network If you live in Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, or Warren County you pay a $1,000 yearly deductible. Contact the plan for services that apply. If you live in Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, or Westmoreland County you pay a $1,200 yearly deductible. Contact the plan for services that apply. $3,400 out-of-pocket limit.	General Premiums range from $51 to $55 in addition to your monthly Medicare Part B premium. Please refer to the premium table located after this section to find out what the premium is in your area. Out-of-Network $500 yearly deductible. Contact the plan for services that apply. In and Out-of-Network $3,400 out-of-pocket limit.	General Premiums range from $133 to $167 in addition to your monthly Medicare Part B premium. Please refer to the premium table located after this section to find out what the premium is in your area. Out-of-Network $500 yearly deductible. Contact the plan for services that apply. In and Out-of-Network $3,400 out-of-pocket limit.	General Premiums range from $179 to $218 in addition to your monthly Medicare Part B premium. Please refer to the premium table located after this section to find out what the premium is in your area. Out-of-Network $500 yearly deductible. Contact the plan for services that apply. In and Out-of-Network $3,400 out-of-pocket limit.

		There is no limit on cost sharing for the following services: In-Network Medicare Services • Ambulance Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Nutrition Therapy for Diabetes and Renal Disease	There is no limit on cost sharing for the following services: In-Network Medicare Services • Home Health Care • Ambulance Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Partial Hospitalization • Nutrition Therapy for Diabetes and Renal Disease	There is no limit on cost sharing for the following services: In-Network Medicare Services • Home Health Care • Ambulance Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Partial Hospitalization • Nutrition Therapy for Diabetes and Renal Disease	There is no limit on cost sharing for the following services: In-Network Medicare Services • Home Health Care • Ambulance Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Partial Hospitalization • Nutrition Therapy for Diabetes and Renal Disease

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IMPORTANT INFORMATION					
1 - Premium and Other Important Information *(Continued)*		In-Network This limit includes only Medicare-covered services. Out-of-Network Medicare Services • Ambulance Services • Urgently Needed Care • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Nutrition Therapy for Diabetes and Renal Disease	In-Network This limit includes only Medicare-covered services. Out-of-Network Medicare Services • Ambulance Services • Urgently Needed Care • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Nutrition Therapy for Diabetes and Renal Disease	In-Network This limit includes only Medicare-covered services. Out-of-Network Medicare Services • Ambulance Services • Urgently Needed Care • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Nutrition Therapy for Diabetes and Renal Disease	In-Network This limit includes only Medicare-covered services. Out-of-Network Medicare Services • Ambulance Services • Urgently Needed Care • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • End Stage Renal Disease • Vision Services • Physical Exams • Health/Wellness Education • Nutrition Therapy for Diabetes and Renal Disease

		Out-of-Network This limit includes only Medicare-covered services.	Out-of-Network This limit includes only Medicare-covered services.	Out-of-Network This limit includes only Medicare-covered services.	Out-of-Network This limit includes only Medicare-covered services.
2 - Doctor and Hospital Choice *(For more information, see Emergency - #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. Out-of-Network Plan covers you when you travel in the U.S.	In-Network No referral required for network doctors, specialists, and hospitals. Out-of-Network Plan covers you when you travel in the U.S.	In-Network No referral required for network doctors, specialists, and hospitals. Out-of-Network Plan covers you when you travel in the U.S.	In-Network No referral required for network doctors, specialists, and hospitals. Out-of-Network Plan covers you when you travel in the U.S.
SUMMARY OF BENEFITS					
INPATIENT CARE					
3 - Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	In 2009 the amounts for each benefit period were: • Days 1 - 60: $1,068 deductible • Days 61 - 90: $267 per day • Days 91 - 150: $534 per lifetime reserve day These amounts will change for 2010. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.	In-Network $0 copay. No limit to the number of days covered by the plan each benefit period. 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 $200 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days. $600 out-of-pocket limit every year. No limit to the number of days covered by the plan each benefit period. 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 $100 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days. $300 out-of-pocket limit every year. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network 20% of the cost for each hospital stay.	In-Network $0 copay. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network 20% of the cost for each hospital stay.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
INPATIENT CARE					
3 - Inpatient Hospital Care *(Continued)*	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 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	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above.) 190 day lifetime limit in a Psychiatric Hospital.	In-Network $0 copay. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	In-Network $200 copay for each Medicare-covered hospital stay. The maximum out-of-pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	In-Network $100 copay for each Medicare-covered hospital stay. The maximum out-of-pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	In-Network $0 copay. You get up to 190 days in a Psychiatric Hospital in a lifetime. 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.	Out-of-Network 30% of the cost for each hospital stay.	Out-of-Network 20% of the cost for each hospital stay.	Out-of-Network 20% of the cost for each hospital stay.
5 - Skilled Nursing Facility (SNF) *(in a Medicare-certified skilled nursing facility)*	In 2009 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: $133.50 per day These amounts will change for 2010. 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 $0 copay for SNF services. Plan covers up to 100 days each benefit period. No prior hospital stay is required. Out-of-Network 30% of the cost for each SNF stay.	General Authorization rules may apply. In-Network For SNF stays: • Days 1 - 15: $0 copay per day • Days 16 - 55: $60 copay per day • Days 56 - 100: $0 copay per day $2,400 out-of-pocket limit every year. Plan covers up to 100 days each benefit period. No prior hospital stay is required. Out-of-Network 30% of the cost for each SNF stay.	General Authorization rules may apply. In-Network For SNF stays: • Days 1 - 15: $0 copay per day • Days 16 - 55: $50 copay per day • Days 56 - 100: $0 copay per day $2,000 out-of-pocket limit every year. Plan covers up to 100 days each benefit period. No prior hospital stay is required. Out-of-Network 20% of the cost for each SNF stay.	General Authorization rules may apply. In-Network For SNF stays: • Days 1 - 15: $0 copay per day • Days 16 - 55: $25 copay per day • Days 56 - 100: $0 copay per day $1,000 out-of-pocket limit every year. Plan covers up to 100 days each benefit period. No prior hospital stay is required. Out-of-Network 20% of the cost for each SNF stay.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
INPATIENT CARE					
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% for home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits. Out-of-Network 30% for home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits. Out-of-Network 20% for home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits. Out-of-Network 20% for home health visits.
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.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE					
8 - Doctor Office Visits	20% coinsurance.	General See “Physical Exams,” for more information. In-Network $15 copay for each primary care doctor visit for Medicare-covered benefits. $15 copay for each in-area, network urgent care Medicare-covered visit.	General See “Physical Exams,” for more information. In-Network $20 copay for each primary care doctor visit for Medicare-covered benefits. $30 copay for each in-area, network urgent care Medicare-covered visit.	General See “Physical Exams,” for more information. In-Network $10 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit.	General See “Physical Exams,” for more information. In-Network $0 copay for each primary care doctor visit for Medicare-covered benefits. $10 copay for each in-area, network urgent care Medicare-covered visit.

		$15 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 30% for each primary care doctor visit. 30% for each specialist visit.	$30 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 30% for each primary care doctor visit. 30% for each specialist visit.	$25 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit.	$10 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit.
9 - Chiropractic Services	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.	In-Network $0 copay for Medicare-covered chiropractic visits. 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 or other qualified providers. Out-of-Network 30% of the cost for chiropractic benefits.	In-Network $30 copay for each Medicare-covered 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 or other qualified providers. Out-of-Network 30% of the cost for chiropractic benefits.	In-Network $25 copay for each Medicare-covered visit. $25 copay for up to 8 routine 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 or other qualified providers. Out-of-Network 20% of the cost for chiropractic benefits.	In-Network $10 copay for each Medicare-covered visit. $10 copay for up to 8 routine 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 or other qualified providers. Out-of-Network 20% of the cost for chiropractic benefits.
10 - Podiatry Services	Routine care not covered. 20% coinsurance for medically-necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network $0 copay for Medicare-covered podiatry benefits.	In-Network $30 copay for each Medicare-covered visit.	In-Network $25 copay for each Medicare-covered visit. $25 copay for up to 10 routine visit(s) every year.	In-Network $10 copay for each Medicare-covered visit. $10 copay for up to 10 routine visit(s) every year.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
OUTPATIENT CARE					
10 - Podiatry Services *(Continued)*		Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 30% of the cost for podiatry benefits.	Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 30% of the cost for podiatry benefits.	Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 20% of the cost for podiatry benefits.	Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network 20% of the cost for podiatry benefits.
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered Mental Health visits. $15 copay for each Medicare-covered individual or group therapy visit with a psychiatrist. Out-of-Network 30% of the cost for Mental Health benefits. 30% of the cost for Mental Health benefits with a psychiatrist.	General Authorization rules may apply. In-Network $30 copay for each Medicare-covered individual or group therapy visit. Out-of-Network 30% of the cost for Mental Health benefits. 30% of the cost for Mental Health benefits with a psychiatrist.	General Authorization rules may apply. In-Network $25 copay for each Medicare-covered individual or group therapy visit. Out-of-Network 20% of the cost for Mental Health benefits. 20% of the cost for Mental Health benefits with a psychiatrist.	General Authorization rules may apply. In-Network $10 copay for each Medicare-covered individual or group therapy visit. Out-of-Network 20% of the cost for Mental Health benefits. 20% of the cost for Mental Health benefits with a psychiatrist.
12 - Outpatient Substance Abuse Care	20% coinsurance.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $10 copay for Medicare-covered individual or group visits.

		Out-of-Network 30% of the cost for outpatient substance abuse benefits.	Out-of-Network 30% of the cost for outpatient substance abuse benefits.	Out-of-Network 20% of the cost for outpatient substance abuse benefits.	Out-of-Network 20% of the cost for outpatient substance abuse benefits.
13 - Outpatient Services/ Surgery	20% coinsurance for the doctor. 20% of outpatient facility charges.	General Authorization rules may apply. In-Network $0 copay for each Medicare-covered ambulatory surgical center visit. $0 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.	General Authorization rules may apply. In-Network $100 copay for each Medicare-covered ambulatory surgical center visit. $100 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.	General Authorization rules may apply. In-Network $50 copay for each Medicare-covered ambulatory surgical center visit. $50 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network 20% of the cost for ambulatory surgical center benefits. 20% of the cost for outpatient hospital facility benefits.	General Authorization rules may apply. In-Network $0 copay for each Medicare-covered ambulatory surgical center visit. $0 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network 20% of the cost for ambulatory surgical center benefits. 20% of the cost for outpatient hospital facility benefits.
14 - Ambulance Services *(medically necessary ambulance services)*	20% coinsurance.	In-Network $0 copay for Medicare-covered ambulance benefits. Out-of-Network 30% of the cost for ambulance benefits. See page 41 for additional information about Ambulance Services.	In-Network $100 copay for Medicare-covered ambulance benefits. Out-of-Network $100 copay or 30% of the cost for ambulance benefits. See page 41 for additional information about Ambulance Services.	In-Network $100 copay for Medicare-covered ambulance benefits. Out-of-Network $100 copay or 20% of the cost for ambulance benefits. See page 41 for additional information about Ambulance Services.	In-Network $25 copay for Medicare-covered ambulance benefits. Out-of-Network $25 copay or 20% of the cost for ambulance benefits. See page 41 for additional information about Ambulance Services.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
OUTPATIENT CARE					
15 - Emergency Care *(You may go to any emergency room if you reasonably believe you need emergency care.)*	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General $50 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 $50 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 $50 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 $0 copay for Medicare-covered emergency room visits. Worldwide coverage.
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 $15 to $50 copay for Medicare-covered urgently needed care visits. See page 41 for additional information about Urgently Needed Care.	General $30 to $50 copay for Medicare-covered urgently needed care visits. See page 41 for additional information about Urgently Needed Care.	General $25 to $50 copay for Medicare-covered urgently needed care visits. See page 41 for additional information about Urgently Needed Care.	General $0 to $10 copay for Medicare-covered urgently needed care visits. See page 41 for additional information about Urgently Needed Care.
17 - Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	20% coinsurance.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered Occupational Therapy visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered Occupational Therapy visits.	General Authorization rules may apply. In-Network $25 copay for Medicare-covered Occupational Therapy visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered Occupational Therapy visits.

		$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 30% of the cost for Occupational Therapy benefits. 30% of the cost for Physical and/or Speech/ Language Therapy visits. See page 41 for additional information about Outpatient Rehabilitation Services.	$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 30% of the cost for Occupational Therapy benefits. 30% of the cost for Physical and/or Speech/ Language Therapy visits. See page 41 for additional information about Outpatient Rehabilitation Services.	$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 20% of the cost for Occupational Therapy benefits. 20% of the cost for Physical and/or Speech/ Language Therapy visits. See page 41 for additional information about Outpatient Rehabilitation Services.	$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. Out-of-Network 20% of the cost for Occupational Therapy benefits. 20% of the cost for Physical and/or Speech/ Language Therapy visits. See page 41 for additional information about Outpatient Rehabilitation Services.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES					
18 - Durable Medical Equipment *(includes wheelchairs, oxygen, etc.)*	20% coinsurance.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered items. Out-of-Network 50% of the cost for durable medical equipment. See page 41 for additional information about Durable Medical Equipment.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for durable medical equipment. See page 41 for additional information about Durable Medical Equipment.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for durable medical equipment. See page 41 for additional information about Durable Medical Equipment.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for durable medical equipment. See page 41 for additional information about Durable Medical Equipment.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES					
19 - Prosthetic Devices *(includes braces, artificial limbs and eyes, etc.)*	20% coinsurance.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered items. Out-of-Network 50% of the cost for prosthetic devices. See page 41 for additional information about Prosthetic Devices.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for prosthetic devices. See page 41 for additional information about Prosthetic Devices.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for prosthetic devices. See page 41 for additional information about Prosthetic Devices.	General Authorization rules may apply. In-Network 15% of the cost for Medicare-covered items. Out-of-Network 50% of the cost for prosthetic devices. See page 41 for additional information about Prosthetic Devices.
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies *(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)*	20% coinsurance. 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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies. Separate office visit cost sharing of $15 copay may apply. Out-of-Network 50% of the cost for Diabetes supplies. $0 copay for Diabetes self-monitoring training.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network 50% of the cost for Diabetes supplies. $0 copay for Diabetes self-monitoring training.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network 50% of the cost for Diabetes supplies. $0 copay for Diabetes self-monitoring training.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 15% of the cost for Diabetes supplies. Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network 50% of the cost for Diabetes supplies. $0 copay for Diabetes self-monitoring training.

		$0 copay for Nutrition Therapy for Diabetes. See page 41 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies.	$0 copay for Nutrition Therapy for Diabetes. See page 41 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies.	$0 copay for Nutrition Therapy for Diabetes. See page 41 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies.	$0 copay for Nutrition Therapy for Diabetes. See page 41 for additional information about Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies.
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 routine screening tests, like checking your cholesterol.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • x-rays • diagnostic radiology services (not including x-rays) • therapeutic radiology services Separate office visit cost sharing of $15 copay may apply. Out-of-Network 30% of the cost for diagnostic procedures, tests, and lab services.	General Authorization rules may apply. In-Network $20 to $50 copay for Medicare-covered lab services. $20 to $50 copay for Medicare-covered diagnostic procedures and tests. $20 to $50 copay for Medicare-covered x-rays. $20 to $50 copay for Medicare-covered diagnostic radiology services. $0 copay for Medicare-covered therapeutic radiology services. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network 30% of the cost for diagnostic procedures, tests, and lab services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $10 to $50 copay for Medicare-covered x-rays. $10 to $50 copay for Medicare-covered diagnostic radiology services. $0 copay for Medicare-covered therapeutic radiology services. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • x-rays • diagnostic radiology services (not including x-rays) • therapeutic radiology services Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES					
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services *(Continued)*		30% of the cost for therapeutic radiology services. 30% of the cost for outpatient x-rays. 30% of the cost for diagnostic radiology services.	30% of the cost for therapeutic radiology services. 30% of the cost for outpatient x-rays. 30% of the cost for diagnostic radiology services.	20% of the cost for therapeutic radiology services. 20% of the cost for outpatient x-rays. 20% of the cost for diagnostic radiology services.	20% of the cost for therapeutic radiology services. 20% of the cost for outpatient x-rays. 20% of the cost for diagnostic radiology services.
PREVENTIVE SERVICES					
22 - Bone Mass Measurement *(for people with Medicare who are at risk)*	20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network $0 copay for Medicare-covered bone mass measurement. Separate office visit cost sharing of $15 copay may apply. Out-of-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement. Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network $0 copay for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams *(for people with Medicare age 50 and older)*	20% coinsurance. Covered when you are high risk or when you are age 50 and older.	In-Network $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $15 copay may apply. Out-of-Network $0 copay for colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network $0 copay for colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network $0 copay for colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network $0 copay for colorectal screenings.

24 - Immunizations *(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)*	$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Out-of-Network $0 copay for immunizations.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Out-of-Network $0 copay for immunizations.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Out-of-Network $0 copay for immunizations.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Out-of-Network $0 copay for immunizations.
25 - Mammograms (Annual Screening) *(for women with Medicare age 40 and older)*	20% coinsurance. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $15 copay may apply. Out-of-Network $0 copay for screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network $0 copay for screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network $0 copay for screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network $0 copay for screening mammograms.
26 - Pap Smears and Pelvic Exams *(for women with Medicare)*	$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams. • Up to 1 additional pap smear(s) and pelvic exam(s) every year. Separate office visit cost sharing of $15 copay may apply.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams. • Up to 1 additional pap smear(s) and pelvic exam(s) every year. Separate office visit cost sharing of $20 to $30 copay may apply.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams. • Up to 1 additional pap smear(s) and pelvic exam(s) every year. Separate office visit cost sharing of $10 to $25 copay may apply.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams. • Up to 1 additional pap smear(s) and pelvic exam(s) every year. Separate office visit cost sharing of $0 to $10 copay may apply.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
PREVENTIVE SERVICES					
26 - Pap Smears and Pelvic Exams *(Continued)*		Out-of-Network $0 copay for pap smears and pelvic exams.	Out-of-Network $0 copay for pap smears and pelvic exams.	Out-of-Network $0 copay for pap smears and pelvic exams.	Out-of-Network $0 copay for pap smears and pelvic exams.
27 - Prostate Cancer Screening Exams *(for men with Medicare age 50 and older)*	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	In-Network $0 copay for Medicare-covered prostate cancer screening. Separate office visit cost sharing of $15 copay may apply. Out-of-Network $0 copay for prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening. Separate office visit cost sharing of $20 to $30 copay may apply. Out-of-Network $0 copay for prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening. Separate office visit cost sharing of $10 to $25 copay may apply. Out-of-Network $0 copay for prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening. Separate office visit cost sharing of $0 to $10 copay may apply. Out-of-Network $0 copay for prostate cancer screening.
28 - End Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for Nutrition Therapy for End Stage Renal Disease. 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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	In-Network $0 copay for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. Out-of-Network 30% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. See page 41 for additional information about End Stage Renal Disease.	In-Network $0 copay for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. Out-of-Network 30% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. See page 41 for additional information about End Stage Renal Disease.	In-Network $0 copay for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. Out-of-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. See page 41 for additional information about End Stage Renal Disease.	In-Network $0 copay for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. Out-of-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End Stage Renal Disease. See page 41 for additional information about End Stage Renal Disease.

29 - 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 $0 copay for Part B-covered drugs. 30% of the cost for Part B drugs out of network Drugs Covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://highmark.medicare-approvedformularies.com/ 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).	Drugs covered under Medicare Part B General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 30% of the cost for Part B drugs out of network. Drugs Covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://highmark.medicare-approvedformularies.com/ 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).	Drugs covered under Medicare Part B General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out of network. Drugs Covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://highmark.medicare-approvedformularies.com/ 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).	Drugs covered under Medicare Part B General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out of network. Drugs Covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://highmark.medicare-approvedformularies.com/ 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).

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*		The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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 the plan. Some drugs have quantity limits. Your provider must get prior authorization from FreedomBlue PPO HD Rx (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the	The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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 the plan. Some drugs have quantity limits. Your provider must get prior authorization from FreedomBlue PPO Select (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the	The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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 the plan. Some drugs have quantity limits. Your provider must get prior authorization from FreedomBlue PPO Classic (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the	The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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 the plan. Some drugs have quantity limits. Your provider must get prior authorization from FreedomBlue PPO Platinum (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the

		plan's Web site, formulary, and 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 FreedomBlue PPO HD Rx (PPO) approves the exception, you will pay Preferred Brand cost sharing. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy Generic • $7 copay for a one-month (34-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier	plan's Web site, formulary, and 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 FreedomBlue PPO Select (PPO) approves the exception, you will pay Preferred Brand cost sharing. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy Generic • $7 copay for a one-month (34-day) supply of drug in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier	plan's Web site, formulary, and 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 FreedomBlue PPO Classic (PPO) approves the exception, you will pay Preferred Brand cost sharing. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy Generic • $7 copay for a one-month (34-day) supply of drugs in this tier • $21 copay for a three-month (90-day) supply of drugs in this tier	plan's Web site, formulary, and 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 FreedomBlue PPO Platinum (PPO) approves the exception, you will pay Preferred Brand cost sharing. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy Generic • $6 copay for a one-month (34-day) supply of drugs in this tier • $18 copay for a three-month (90-day) supply of drugs in this tier

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*		Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier • $240 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Preferred Brand • $40 copay for a one-month (34-day) supply of drugs in this tier • $120 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier • $240 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

		Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $42 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $90 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $45 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $90 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $42 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Generic • $6 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $40 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*		Mail Order Generic • $17.50 copay for a one-month (34-day) supply of drugs in this tier • $17.50 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Preferred Brand • $105 copay for a one-month (34-day) supply of drugs in this tier • $105 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $225 copay for a one-month (34-day) supply of drugs in this tier	Mail Order Generic • $17.50 copay for a one-month (34-day) supply of drugs in this tier • $17.50 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Preferred Brand • $112.50 copay for a one-month (34-day) supply of drugs in this tier • $112.50 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $225 copay for a one-month (34-day) supply of drugs in this tier	Mail Order Generic • $17.50 copay for a one-month (34-day) supply of drugs in this tier • $17.50 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Preferred Brand • $105 copay for a one-month (34-day) supply of drugs in this tier • $105 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $200 copay for a one-month (34-day) supply of drugs in this tier	Mail Order Generic • $15 copay for a one-month (34-day) supply of drugs in this tier • $15 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Preferred Brand • $100 copay for a one-month (34-day) supply of drugs in this tier • $100 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Non-Preferred Brand • $200 copay for a one-month (34-day) supply of drugs in this tier

		• $225 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	• $225 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	• $200 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	• $200 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Specialty • 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 Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Coverage Gap The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: Retail Pharmacy Generic • $6 copay for a one-month (34-day) supply of all drugs covered in this tier

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*					• $18 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. Long Term Care Pharmacy Generic • $6 copay for a one-month (34-day) supply of all drugs covered in this tier Mail Order Generic • $15 copay for a one-month (34-day) supply of all drugs covered in this tier • $15 copay for a three-month (90-day) supply of all drugs covered in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. For all other covered drugs, after your total yearly drug costs reach

					$2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550. Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. 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 FreedomBlue PPO Platinum (PPO).
		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. 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 FreedomBlue PPO HD Rx (PPO).	Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. 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 FreedomBlue PPO Select (PPO).	Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. 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 FreedomBlue PPO Classic (PPO).	Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. 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 FreedomBlue PPO Platinum (PPO).

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*		Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out of network until total yearly drug costs reach $2,830: Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $42 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $90 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge	Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out of network until total yearly drug costs reach $2,830: Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $45 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $90 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge	Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out of network until total yearly drug costs reach $2,830: Generic • $7 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $42 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge	Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out of network until total yearly drug costs reach $2,830: Generic • $6 copay for a one-month (34-day) supply of drugs in this tier Preferred Brand • $40 copay for a one-month (34-day) supply of drugs in this tier Non-Preferred Brand • $80 copay for a one-month (34-day) supply of drugs in this tier Specialty • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out of network up to the full cost of the drug

		for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO HD Rx (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO HD Rx (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year.	for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO Select (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO Select (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year.	for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO Classic (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO Classic (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year.	minus the following: Generic • $6 copay for a one-month (34-day) supply of all drugs covered in this tier Preferred Brand • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO Platinum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO Platinum (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year. Non-Preferred Brand • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
29 - Prescription Drugs *(Continued)*					Platinum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO Platinum (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year. Specialty • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out of network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by FreedomBlue PPO Platinum (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to FreedomBlue PPO Platinum (PPO) so we can add the amounts you spent out of network to your total out-of-pocket costs for the year.

		Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out of network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. See page 41 for additional information about Prescription Drugs.	Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out of network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. See page 41 for additional information about Prescription Drugs.	Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out of network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. See page 41 for additional information about Prescription Drugs.	Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out of network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. See page 41 for additional information about Prescription Drugs.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	General Authorization rules may apply. In-Network 0% of the cost 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 visit(s) every year	General Authorization rules may apply. In-Network In general, preventive dental benefits (such as cleaning) not covered. $30 copay for Medicare-covered dental benefits.	General Authorization rules may apply. In-Network $25 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 visit(s) every year	General Authorization rules may apply. In-Network $10 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 visit(s) every year

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
30 - Dental Services *(Continued)*		Out-of-Network 50% of the cost for preventive dental benefits. • 30% to 50% of the cost for comprehensive dental benefits In and Out-of-Network Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. See page 42 for additional information about Dental Services.	Out-of-Network 30% of the cost for comprehensive dental benefits. See page 42 for additional information about Dental Services.	Out-of-Network 50% of the cost for preventive dental benefits. • 20% to 50% of the cost for comprehensive dental benefits In and Out-of-Network Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. See page 42 for additional information about Dental Services.	Out-of-Network 50% of the cost for preventive dental benefits. • 20% to 50% of the cost for comprehensive dental benefits In and Out-of-Network Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits. See page 42 for additional information about Dental Services.
31 - Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network $0 copay for hearing aids. • $15 copay for Medicare-covered diagnostic hearing exams • $15 copay for up to 1 routine hearing test(s) every year $500 limit for hearing aids every three years. Out-of-Network 30% of the cost for hearing exams.	In-Network $0 copay for hearing aids. • $30 copay for Medicare-covered diagnostic hearing exams • $30 copay for up to 1 routine hearing test(s) every year $500 limit for hearing aids every three years. Out-of-Network 30% of the cost for hearing exams.	In-Network $0 copay for hearing aids. • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 routine hearing test(s) every year $500 limit for hearing aids every three years. Out-of-Network 20% of the cost for hearing exams.	In-Network $0 copay for hearing aids. • $10 copay for Medicare-covered diagnostic hearing exams • $10 copay for up to 1 routine hearing test(s) every year $1,000 limit for hearing aids every three years. Out-of-Network 20% of the cost for hearing exams.

		• $0 copay for hearing aids See page 42 for additional information about Hearing Services.	• $0 copay for hearing aids See page 42 for additional information about Hearing Services.	• $0 copay for hearing aids See page 42 for additional information about Hearing Services.	• $0 copay for hearing aids See page 42 for additional information about Hearing Services.
32 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. 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 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 • $15 copay for exams to diagnose and treat diseases and conditions of the eye • $15 copay for up to 1 routine eye exam(s) every year $100 limit for contact lenses every two years. $100 limit for eyeglass frames every two years.	In-Network $0 copay for • one pair of 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 • $30 copay for exams to diagnose and treat diseases and conditions of the eye • $30 copay for up to 1 routine eye exam(s) every year $100 limit for contact lenses every two years. $100 limit for eyeglass frames every two years.	In-Network $0 copay for • one pair of 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 • $25 copay for exams to diagnose and treat diseases and conditions of the eye • $25 copay for up to 1 routine eye exam(s) every year $100 limit for contact lenses every two years. $100 limit for eyeglass frames every two years.	In-Network $0 copay for • one pair of 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 • $10 copay for exams to diagnose and treat diseases and conditions of the eye • $10 copay for up to 1 routine eye exam(s) every year $100 limit for contact lenses every two years. $100 limit for eyeglass frames every two years.

Benefit Category	Original Medicare	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
32 - Vision Services *(Continued)*		Out-of-Network 30% of the cost for eye exams. 30% of the cost for eye wear. See page 42 for additional information about Vision Services.	Out-of-Network 30% of the cost for eye exams. 30% of the cost for eye wear. See page 42 for additional information about Vision Services.	Out-of-Network 20% of the cost for eye exams. 20% of the cost for eye wear. See page 42 for additional information about Vision Services.	Out-of-Network 20% of the cost for eye exams. 20% of the cost for eye wear. See page 42 for additional information about Vision Services.
33 - Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year. Out-of-Network $0 copay for routine exams.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year. Out-of-Network $0 copay for routine exams.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year. Out-of-Network $0 copay for routine exams.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year. Out-of-Network $0 copay for routine exams.
34 - Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits.	In-Network This plan covers the following health/wellness education benefits: • Health Club Membership/Fitness Classes • Other Wellness Benefits	In-Network This plan covers the following health/wellness education benefits: • Health Club Membership/Fitness Classes • Other Wellness Benefits	In-Network This plan covers the following health/wellness education benefits: • Health Club Membership/Fitness Classes • Other Wellness Benefits	In-Network This plan covers the following health/wellness education benefits: • Health Club Membership/Fitness Classes • Other Wellness Benefits

	You pay coinsurance, and Part B deductible applies.	$0 copay for each Medicare-covered smoking cessation counseling session. Out-of-Network 50% of the cost for Health and Wellness services. See page 42 for additional information about Health/Wellness Education Services.	$0 copay for each Medicare-covered smoking cessation counseling session. Out-of-Network 50% of the cost for Health and Wellness services. See page 42 for additional information about Health/Wellness Education Services.	$0 copay for each Medicare-covered smoking cessation counseling session. Out-of-Network 50% of the cost for Health and Wellness services. See page 42 for additional information about Health/Wellness Education Services.	$0 copay for each Medicare-covered smoking cessation counseling session. Out-of-Network 50% of the cost for Health and Wellness services. See page 42 for additional information about Health/Wellness Education Services.
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover acupuncture.	In-Network This plan does not cover acupuncture.	In-Network This plan does not cover acupuncture.	In-Network This plan does not cover acupuncture.

HIGHMARK FREEDOMBLUE PPO
A Medicare Advantage PPO

The following chart shows the monthly premium for the FreedomBlue PPO plans in your area. Please select your county of residence in the first column to see the monthly premium for the FreedomBlue PPO plan of your choice.

	FreedomBlue PPO HD Rx (PPO)	FreedomBlue PPO Select (PPO)	FreedomBlue PPO Classic (PPO)	FreedomBlue PPO Platinum (PPO)
Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland	$0	$55	$167	$218
Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, Warren	$0	$51	$133	$179

Section Three:

Important Plan Information

HIGHMARK. FREEDOMBLUE PPO
A Medicare Advantage PPO

The following is additional important information about some of the benefits listed in Section 2 of this Summary of Benefits. Please take a moment to review these details. For a complete listing of plan benefits, be sure to reference the FreedomBlue PPO "Evidence of Coverage."

New For 2010—Blue Cross Blue Shield Visitor/Traveler Benefit

In addition to standard network and out-of-network benefits, all FreedomBlue PPO members have access to the Blue Cross Blue Shield Visitor and Travel Program beginning January 1, 2010. FreedomBlue PPO members who see participating Medicare Advantage PPO providers in any geographic area where the Visitor and Travel Program is offered will pay the same network cost-sharing level they would pay if they received covered benefits from network providers in the FreedomBlue PPO service area.

The Program is available outside the FreedomBlue PPO service area in the following 17 states and 1 territory: Alabama, California, Florida, Idaho, Indiana, Kentucky, Massachusetts, Michigan, Missouri, North Carolina, Nevada, New York, Ohio, Puerto Rico, South Carolina, Tennessee, Wisconsin and West Virginia. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state.

To find Blue Cross Blue Shield Medicare Advantage PPO participating providers:

- Members may call FreedomBlue PPO Member Service, seven days a week from 8:00 a.m. to 8:00 p.m. at 1-800-550-8722. Hearing-impaired TTY users call 1-800-988-0668. Prospective members should call 1-800-350-1973. (TTY/TDD 1-800-862-0709).
- Call 1-800-810-BLUE (1-800-810-2583), 24 hours a day, seven days a week; hearing-impaired TTY users may call 711.
- Visit www.highmarkbcbs.com and select "Find Providers" or visit the "Doctor Hospital Finder" at www.BCBS.com.

FreedomBlue PPO members can see any Blue Cross Blue Shield Medicare Advantage PPO contracted doctor or hospital outside the FreedomBlue PPO service area in the above 17 states and 1 territory and receive coverage at the highest level of benefits. If you receive routine care from non-Blue Cross Blue Shield Medicare Advantage PPO providers in the above 17 states and 1 territory, you will have a lower level of benefits, which will result in higher out-of-pocket costs. However, you won't pay extra in a medical emergency or if your care is urgently needed.

Other Benefits

Ambulance Services – The copay for ambulance services is per one-way trip. That means a round trip would be two copays. The copay applies to ground, air, wheelchair accessible and other types of ambulance transportation services. You should obtain authorization for out-of-network non-emergent ambulance services. Wheelchair vans or non-emergent ambulance transport are only covered when Certified Medically Necessary.

Urgently Needed Care – The copay for urgently needed care is the same as your emergency room copay if the care is received in a hospital. The copay may be the lesser amount if the care is received in a location other than a hospital. Network urgent care services are excluded from the plan out-of-pocket maximum.

Outpatient Rehabilitation Services – You pay cost sharing for each separate network Occupational, Physical, Speech and Language Therapy visit per provider, even if obtained in the same day.

Durable Medical Equipment (DME), Prosthetic Devices, Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies – The network and out-of-network DME coinsurance applies to all durable medical items and medical supplies (including diabetes Self-Monitoring equipment and supplies) except oxygen and oxygen supplies. The maximum annual network coinsurance amount you will pay is $500. Durable Medical Equipment and Prosthetic Devices obtained out of network are subject to a separate $500 benefit deductible. Oxygen-related DME is covered in full and excluded from the deductible. You should obtain precertification for all oxygen services received out of network.

End Stage Renal Disease – FreedomBlue PPO pays 100% of the cost for Renal Dialysis Services received inside the network and 100% coverage for Renal Dialysis Services received outside of the service area. If you obtain Renal Dialysis Services at an out-of-network provider located within FreedomBlue PPO's service area, you will pay the coinsurance listed.

Prescription Drugs (Medicare Part B Drugs) – Certain categories of Medicare Part B drugs have been excluded from the coinsurance. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via the retail pharmacy network. Part B drugs are subject to a $300 quarterly out-of-pocket maximum.

Section Three: *Continued*

Dental Services – FreedomBlue PPO plans that cover routine/preventive dental services allow for one set of bitewing x-rays once per calendar year and full mouth x-rays once every five calendar years. Members are also covered for one cleaning and oral exam every six months, as well as for restorative services and simple extractions.

In addition, FreedomBlue PPO plans that cover routine/preventive services also have coverage for a denture benefit, which is available once every five years. It also offers preventive denture maintenance every three years including denture repair and realignment. Dentures and maintenance are covered at 40% in network and 50% out of network. Initial denture relining, rebasing or adjustments are considered part of the denture charges if provided within six months of insertion by the same dentist.

All coverage for routine/preventive dental services, as well as dentures, is subject to the coinsurance listed with the FreedomBlue PPO plan offering the coverage. Not all FreedomBlue PPO plans provide this coverage.

Hearing Services – The benefit maximum for hearing aids is a combined benefit, meaning it applies to both network and/or out-of-network benefits.

Vision Services – The routine eye wear benefit is limited to one pair of eyeglass frames with either one pair of eyeglass lenses or contact lenses every two calendar years. Standard frames, eyeglass lenses, or contact lenses are covered in full at participating network provider locations. A $100 benefit maximum is available towards the purchase of non-standard eyeglass frames or specialty contact lenses at participating network provider locations. Members utilizing the out-of-network routine eye wear benefit are subject to a $100 benefit maximum.

Health/Wellness Education – A $250 out-of-network benefit deductible applies before 50% coinsurance is applicable.

HIGHMARK. FREEDOMBLUE PPO
A Medicare Advantage PPO

Southwest and West Central Pennsylvania

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