2012 FreedomBlue PPO Summary of Benefits

- Residents of the following counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties, please click here.

- Residents of the following counties: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango and Warren counties, please click here.

2012 Summary of Benefits

HIGHMARK. FreedomBlue PPO

FreedomBlue℠ PPO

Southwest Pennsylvania

H3916_11_0233 CMS Approved (08/22/2011)

Contract Number H3916

January 1, 2012 through December 31, 2012

FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (PPO)

January 1, 2012 - December 31, 2012

SOUTHWESTERN PA

HIGHMARK®
FreedomBlue PPO

Thank you for your interest in FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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) and Classic (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) and Classic (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) and Classic (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 IS FREEDOMBLUE PPO HD RX (PPO), SELECT (PPO) AND CLASSIC (PPO) AVAILABLE?

The service area for this plan includes: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, 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) AND CLASSIC (PPO)?

You can join FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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) and Classic (PPO) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at www.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.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

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

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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 MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to

For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call 1-800-550-8722, (TTY users (888)-422-1226) and prospective members call 1-866-682-7969, (TTY users (711)).

continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

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

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

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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 Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant 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 administered through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

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

Please call Highmark Inc. for more information about FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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 (800)-550-8722 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (888)-422-1226)

Prospective members should call toll-free (866)-682-7969 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (711))

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

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

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For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call 1-800-550-8722, (TTY users (888)-422-1226) and prospective members call 1-866-682-7969, (TTY users (711)).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
IMPORTANT INFORMATION				
1 - Premium and Other Important Information	In 2011 the monthly Part B Premium was $96.40 and may change for 2012 and the annual Part B deductible amount was $162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not	**General** $76 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not	**General** $205 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not

		apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. Highmark Inc. will reduce your monthly Medicare Part B premium by up to $3.00. **In-Network** $3,000 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $1,250 annual deductible. Contact the plan for services that apply. $4,500 out-of-pocket limit for Medicare-covered services.	apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **Out-of-Network** $500 annual deductible. Contact the plan for services that apply. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.	apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **Out-of-Network** $500 annual deductible. Contact the plan for services that apply. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.
2 - Doctor and Hospital Choice *(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)*	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits. **Out of Service Area** Plan covers you when you travel in the U.S.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
SUMMARY OF BENEFITS				
INPATIENT CARE				
3 - Inpatient Hospital Care *(includes Substance Abuse and Rehabilitation Services)*	In 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a 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.	**In-Network** No limit to the number of days covered by the plan each hospital stay. 10% of the cost for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $400 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 20% of the cost for each hospital stay.
4 - Inpatient Mental Health Care	In 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions

	Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. 10% of the cost for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $400 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $300 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 20% of the cost for each hospital stay.
5 - Skilled Nursing Facility (SNF) *(in a Medicare-certified skilled nursing facility)*	In 2011 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: $141.50 per day These amounts may change for 2012. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. 10% of the cost for each SNF stay. **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 15: $0 copay per day Days 16 - 75: $60 copay per day Days 76 - 100: $0 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 15: $0 copay per day Days 16 - 75: $50 copay per day Days 76 - 100: $0 copay per day **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)
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% of the cost for home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 20% of the cost 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. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE				
8 - Doctor Office Visits	20% coinsurance	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 30% of the cost for each primary care doctor visit 30% of the cost for each specialist visit	**In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $30 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 30% of the cost for each primary care doctor visit 30% of the cost for each specialist visit	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 20% of the cost for each primary care doctor visit 20% of the cost for each specialist visit

9 - Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $10 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** $20 copay for each Medicare-covered visit $20 copay for up to 8 supplemental 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** 30% of the cost for chiropractic benefits.	**In-Network** $10 copay for each Medicare-covered visit $10 copay for up to 8 supplemental 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	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** 10% of the cost for each Medicare-covered visit Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.	**In-Network** $30 copay for each Medicare-covered visit $30 copay for up to 10 supplemental routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.	**In-Network** $25 copay for each Medicare-covered visit $25 copay for up to 10 supplemental routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 20% of the cost for podiatry benefits.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT CARE				
11 - Outpatient Mental Health Care	40% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** 10% of the cost for each Medicare-covered individual therapy visit 10% of the cost for each Medicare-covered group therapy visit $25 copay for each Medicare-covered individual therapy visit with a psychiatrist $25 copay for each Medicare-covered group therapy visit with a psychiatrist 10% of the cost for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Mental Health benefits with a psychiatrist 30% of the cost for Mental Health benefits 30% of the cost for partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Mental Health benefits with a psychiatrist 30% of the cost for Mental Health benefits 30% of the cost for partial hospitalization program services	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual therapy visit $25 copay for each Medicare-covered group therapy visit $25 copay for each Medicare-covered individual therapy visit with a psychiatrist $25 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 20% of the cost for Mental Health benefits with a psychiatrist 20% of the cost for Mental Health benefits 20% of the cost for partial hospitalization program services

12 - Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered individual visits 10% of the cost for Medicare-covered group visits **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered individual visits $30 copay for Medicare-covered group visits **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual visits $25 copay for Medicare-covered group visits **Out-of-Network** 20% of the cost for outpatient substance abuse benefits.
13 - Outpatient Services/Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** 10% of the cost for each Medicare-covered ambulatory surgical center visit 10% of the cost for each Medicare-covered outpatient hospital facility visit **Out-of-Network** 30% of the cost for outpatient hospital facility benefits. 30% of the cost for ambulatory surgical center benefits.	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit $150 copay for each Medicare-covered outpatient hospital facility visit **Out-of-Network** 30% of the cost for outpatient hospital facility benefits. 30% of the cost for ambulatory surgical center 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** 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory surgical center benefits.
14 - Ambulance Services *(medically necessary ambulance services)*	20% coinsurance	**In-Network** $75 copay for Medicare-covered ambulance benefits. **Out-of-Network** $75 copay [or 30% of the cost] for ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 30% of the cost] for ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 20% of the cost] for ambulance benefits.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (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's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.
16 - Urgently Needed Care *(This is NOT emergency care, and in most cases, is out of the service area.)*	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits

17 - Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	20% coinsurance	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered Occupational Therapy visits 10% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 30% of the cost for Physical and/or Speech and Language Therapy visits 30% of the cost for Occupational Therapy benefits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered Occupational Therapy visits $30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 30% of the cost for Physical and/or Speech and Language Therapy visits 30% of the cost for Occupational Therapy benefits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered Occupational Therapy visits $25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 20% of the cost for Physical and/or Speech and Language Therapy visits 20% of the cost for Occupational Therapy benefits.
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** 0% to 50% of the cost for durable medical equipment	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered items **Out-of-Network** 0% to 50% of the cost for durable medical equipment	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered items **Out-of-Network** 0% to 50% of the cost for durable medical equipment
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.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 50% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 50% of the cost for prosthetic devices.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
20 - Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training 0% to 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $20 to $30 may apply **Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training 0% to 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts

21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	**General** Authorization rules may apply. **In-Network** 0% to 10% of the cost for Medicare-covered lab services 0% to 10% of the cost for Medicare-covered diagnostic procedures and tests 10% of the cost for Medicare-covered X-rays 10% of the cost for Medicare-covered diagnostic radiology services (not including X-rays) 0% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% to 30% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 30% of the cost may apply	**General** Authorization rules may apply. **In-Network** $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $30 to $125 copay for Medicare-covered X-rays $30 to $125 copay for Medicare-covered diagnostic radiology services (not including X-rays) $0 copay for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $20 to $30 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $20 to $30 may apply **Out-of-Network** 0% to 30% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 30% of the cost may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 to $100 copay for Medicare-covered X-rays $20 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) $0 copay for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% to 20% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 20% of the cost may apply

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (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 If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 30% of the cost may apply	30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays 30% of the cost for diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 30% of the cost may apply	20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 20% of the cost may apply
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Cardiac Rehabilitation Services 30% of the cost for Intensive Cardiac Rehabilitation Services 30% of the cost for Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Cardiac Rehabilitation Services 30% of the cost for Intensive Cardiac Rehabilitation Services 30% of the cost for Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 20% of the cost for Cardiac Rehabilitation Services 20% of the cost for Intensive Cardiac Rehabilitation Services 20% of the cost for Pulmonary Rehabilitation Services

PREVENTIVE SERVICES

23 - Preventive Services and Wellness/ Education Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking)

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
23 - Preventive Services and Wellness/ Education Programs *(continued)*	• Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.	• Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 50% of the cost for supplemental education/wellness programs 0% of the cost for Medicare-covered preventive services	• Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/wellness programs	• Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details. **In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/wellness programs

	• Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.			
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** 10% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 30% of the cost for renal dialysis	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 30% of the cost for renal dialysis	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 20% of the cost for renal dialysis

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 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) providers.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 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) providers.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 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) providers.

		The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from 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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.	The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from 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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.	The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from 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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		If you request a formulary exception for a drug and FreedomBlue PPO HD Rx (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier • $30 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $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.	If you request a formulary exception for a drug and FreedomBlue PPO Select (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier • $27 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. **Tier 2: Preferred Brand Drugs** • $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.	If you request a formulary exception for a drug and FreedomBlue PPO Classic (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930: **Retail Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $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.

		Tier 3: Non-Preferred Brand Drugs • $95 copay for a one-month (34-day) supply of drugs in this tier • $285 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 4: Specialty Tier Drugs** • 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** **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	**Tier 3: Non-Preferred Brand Drugs** • $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. **Tier 4: Specialty Tier Drugs** • 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** **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	**Tier 3: Non-Preferred Brand Drugs** • $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. **Tier 4: Specialty Tier Drugs** • 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** **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $42 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 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)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**Mail Order** **Tier 1: Generic Drugs** • $25 copay for a one-month (34-day) supply of drugs in this tier • $25 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. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $237.50 copay for a one-month (34-day) supply of drugs in this tier • $237.50 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.	**Mail Order** **Tier 1: Generic Drugs** • $22.50 copay for a one-month (34-day) supply of drugs in this tier • $22.50 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. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $225 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.	**Mail Order** **Tier 1: Generic Drugs** • $20 copay for a one-month (34-day) supply of drugs in this tier • $20 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. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $225 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.

		Tier 4: Specialty Tier Drugs • 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 $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	**Tier 4: Specialty Tier Drugs** • 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 $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.	**Tier 4: Specialty Tier Drugs** • 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. **Additional Coverage Gap** You pay the following: **Retail Pharmacy** **Tier 1: Generic Drugs** • 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier • 50% coinsurance 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** **Tier 1: Generic Drugs** • 50% coinsurance 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)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.	**Mail Order** **Tier 1: Generic Drugs** • 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier • 50% coinsurance 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. After your total yearly drug costs reach $2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.

		Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from FreedomBlue PPO HD Rx (PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	**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). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier	**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). **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $42 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 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)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Generic Drugs** • 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier **Tier 2: Preferred Brand Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. **Tier 3: Non-Preferred Brand Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.

		Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. **Tier 4: Specialty Tier Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** 10% 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(s) every year **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.	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $30 to $150 copay for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** $25 to $100 copay for Medicare-covered dental benefits • 30% of the cost for up to 1 oral exam(s) every six months • 30% of the cost for up to 1 cleaning(s) every six months • 30% of the cost for up to 1 dental x-ray(s) every year **Out-of-Network** 50% of the cost for 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.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for hearing aids. • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year	**In-Network** $0 copay for hearing aids. • $30 copay for Medicare-covered diagnostic hearing exams • $30 copay for up to 1 supplemental routine hearing exam(s) every year	**In-Network** $0 copay for hearing aids. • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year

		Out-of-Network 30% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	**Out-of-Network** 30% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	**Out-of-Network** 20% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.
28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of 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 • $0 to $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $10 to $25 may apply	**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 • $0 to $30 copay for exams to diagnose and treat diseases and conditions of the eye. • $30 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $20 to $30 may apply	**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 • $0 to $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $10 to $25 may apply

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
28 - Vision Services *(continued)*		$100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply 30% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.	$100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply 30% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.	$100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 20% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 20% of the cost may apply 20% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.

Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation *(Routine)*	Not covered.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

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FreedomBlue PPO

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2012 Summary of Benefits

HIGHMARK. FreedomBlue PPO

FreedomBlue℠ PPO

West Central Pennsylvania

H3916_11_0234 CMS Approved (08/22/2011)

Contract Number H3916

January 1, 2012 through December 31, 2012

FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (PPO)

January 1, 2012 - December 31, 2012

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HIGHMARK® FreedomBlue PPO

Thank you for your interest in FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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) and Classic (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) and Classic (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) and Classic (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 IS FREEDOMBLUE PPO HD RX (PPO), SELECT (PPO) AND CLASSIC (PPO) AVAILABLE?

The service area for this plan includes: Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango, and Warren 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) AND CLASSIC (PPO)?

You can join FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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) and Classic (PPO) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at www.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.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

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

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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 MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in

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their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

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

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

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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) and Classic (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 Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant 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 administered through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

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

Please call Highmark Inc. for more information about FreedomBlue PPO HD Rx (PPO), Select (PPO) and Classic (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 (800)-550-8722 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (888)-422-1226)

Prospective members should call toll-free (866)-682-7969 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD (711))

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

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

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FreedomBlue PPO

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BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
IMPORTANT INFORMATION				
1 - Premium and Other Important Information	In 2011 the monthly Part B Premium was $96.40 and may change for 2012 and the annual Part B deductible amount was $162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the	**General** $73 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the	**General** $166 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the

		higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. Highmark Inc. will reduce your monthly Medicare Part B premium by up to $3.00. **In-Network** $2,750 out-of-pocket limit for Medicare-covered services. **In and Out-of-Network** $1,000 annual deductible. Contact the plan for services that apply. $4,500 out-of-pocket limit for Medicare-covered services.	higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **Out-of-Network** $500 annual deductible. Contact the plan for services that apply. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.	higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type. To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit www.medicare.gov/physician or www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,400 out-of-pocket limit for Medicare-covered services. **Out-of-Network** $500 annual deductible. Contact the plan for services that apply. **In and Out-of-Network** $5,100 out-of-pocket limit for Medicare-covered services.
2 - Doctor and Hospital Choice *(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)*	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	**In-Network** No referral required for network doctors, specialists, and hospitals. **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
IMPORTANT INFORMATION				
2 - Doctor and Hospital Choice *(continued)*		**Out of Service Area** Plan covers you when you travel in the U.S.	**Out of Service Area** Plan covers you when you travel in the U.S.	**Out of Service Area** 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 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a 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.	**In-Network** No limit to the number of days covered by the plan each hospital stay. 10% of the cost for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $400 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** No limit to the number of days covered by the plan each hospital stay. $300 copay for each Medicare-covered hospital stay $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 20% of the cost for each hospital stay.

4 - Inpatient Mental Health Care	In 2011 the amounts for each benefit period were: Days 1 - 60: $1132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. 10% of the cost for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $400 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 30% of the cost for each hospital stay.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. $300 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 20% of the cost for each hospital stay.
5 - Skilled Nursing Facility (SNF) *(in a Medicare-certified skilled nursing facility)*	In 2011 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: $141.50 per day These amounts may change for 2012. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. 10% of the cost for each SNF stay. **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 15: $0 copay per day Days 16 - 75: $60 copay per day Days 76 - 100: $0 copay per day **Out-of-Network** 30% of the cost for each SNF stay.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 15: $0 copay per day Days 16 - 75: $50 copay per day Days 76 - 100: $0 copay per day **Out-of-Network** 20% of the cost for each SNF stay.

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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% of the cost for home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 30% of the cost for home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits **Out-of-Network** 20% of the cost 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. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE				
8 - Doctor Office Visits	20% coinsurance	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 30% of the cost for each primary care doctor visit 30% of the cost for each specialist visit	**In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $30 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 30% of the cost for each primary care doctor visit 30% of the cost for each specialist visit	**In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $50 copay for each in-area, network urgent care Medicare-covered visit $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** 20% of the cost for each primary care doctor visit 20% of the cost for each specialist visit

9 - Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $10 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** $20 copay for each Medicare-covered visit $20 copay for up to 8 supplemental 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** 30% of the cost for chiropractic benefits.	**In-Network** $10 copay for each Medicare-covered visit $10 copay for up to 8 supplemental 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	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** 10% of the cost for each Medicare-covered visit Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.	**In-Network** $30 copay for each Medicare-covered visit $30 copay for up to 10 supplemental routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care. **Out-of-Network** 30% of the cost for podiatry benefits.	**In-Network** $25 copay for each Medicare-covered visit $25 copay for up to 10 supplemental routine visit(s) every year 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	40% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.	**General** Authorization rules may apply. **In-Network** 10% of the cost for each Medicare-covered individual therapy visit 10% of the cost for each Medicare-covered group therapy visit	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit $30 copay for each Medicare-covered group therapy visit	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered individual therapy visit $25 copay for each Medicare-covered group therapy visit

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BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT CARE				
11 - Outpatient Mental Health Care *(continued)*	"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$25 copay for each Medicare-covered individual therapy visit with a psychiatrist $25 copay for each Medicare-covered group therapy visit with a psychiatrist 10% of the cost for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Mental Health benefits with a psychiatrist 30% of the cost for Mental Health benefits 30% of the cost for partial hospitalization program services	$30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 30% of the cost for Mental Health benefits with a psychiatrist 30% of the cost for Mental Health benefits 30% of the cost for partial hospitalization program services	$25 copay for each Medicare-covered individual therapy visit with a psychiatrist $25 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** 20% of the cost for Mental Health benefits with a psychiatrist 20% of the cost for Mental Health benefits 20% of the cost for partial hospitalization program services
12 - Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered individual visits 10% of the cost for Medicare-covered group visits **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered individual visits $30 copay for Medicare-covered group visits **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered individual visits $25 copay for Medicare-covered group visits **Out-of-Network** 20% of the cost for outpatient substance abuse benefits.

13 - Outpatient Services/ Surgery	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** 10% of the cost for each Medicare-covered ambulatory surgical center visit 10% of the cost for each Medicare-covered outpatient hospital facility visit **Out-of-Network** 30% of the cost for outpatient hospital facility benefits. 30% of the cost for ambulatory surgical center benefits.	**General** Authorization rules may apply. **In-Network** $150 copay for each Medicare-covered ambulatory surgical center visit $150 copay for each Medicare-covered outpatient hospital facility visit **Out-of-Network** 30% of the cost for outpatient hospital facility benefits. 30% of the cost for ambulatory surgical center 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** 20% of the cost for outpatient hospital facility benefits. 20% of the cost for ambulatory surgical center benefits.
14 - Ambulance Services *(medically necessary ambulance services)*	20% coinsurance	**In-Network** $75 copay for Medicare-covered ambulance benefits. **Out-of-Network** $75 copay [or 30% of the cost] for ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 30% of the cost] for ambulance benefits.	**In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay [or 20% of the cost] for ambulance benefits.
15 - Emergency Care *(You may go to any emergency room if you reasonably believe you need emergency care.)*	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit.

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BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT CARE				
15 - Emergency Care *(continued)*	the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.			
16 - Urgently Needed Care *(This is NOT emergency care, and in most cases, is out of the service area.)*	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits	**General** $50 copay for Medicare-covered urgently-needed-care visits
17 - Outpatient Rehabilitation Services *(Occupational Therapy, Physical Therapy, Speech and Language Therapy)*	20% coinsurance	**General** Authorization rules may apply. **In-Network** 10% of the cost for Medicare-covered Occupational Therapy visits 10% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 30% of the cost for Physical and/or Speech and Language Therapy visits 30% of the cost for Occupational Therapy benefits.	**General** Authorization rules may apply. **In-Network** $30 copay for Medicare-covered Occupational Therapy visits $30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 30% of the cost for Physical and/or Speech and Language Therapy visits 30% of the cost for Occupational Therapy benefits.	**General** Authorization rules may apply. **In-Network** $25 copay for Medicare-covered Occupational Therapy visits $25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits **Out-of-Network** 20% of the cost for Physical and/or Speech and Language Therapy visits 20% of the cost for Occupational Therapy benefits.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
18 - Durable Medical Equipment *(includes wheelchairs, oxygen, etc.)*		**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items **Out-of-Network** 0% to 50% of the cost for durable medical equipment	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered items **Out-of-Network** 0% to 50% of the cost for durable medical equipment	**General** Authorization rules may apply. **In-Network** 0% to 20% of the cost for Medicare-covered items **Out-of-Network** 0% to 50% of the cost for durable medical equipment
19 - Prosthetic Devices *(includes braces, artificial limbs and eyes, etc.)*		**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered items **Out-of-Network** 50% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 50% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items **Out-of-Network** 50% of the cost for prosthetic devices.
20 - Diabetes Programs and Supplies		**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training $0 copay for: • Diabetes monitoring supplies • Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $25 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training 0% to 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $20 to $30 may apply	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-management training 0% to 20% of the cost for Diabetes monitoring supplies 20% of the cost for Therapeutic shoes or inserts If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of $10 to $25 may apply

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
20 - Diabetes Programs and Supplies *(continued)*		**Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts	**Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts	**Out-of-Network** 0% of the cost for Diabetes self-management training If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply 50% of the cost for Diabetes monitoring supplies 50% of the cost for Therapeutic shoes or inserts
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** 0% to 10% of the cost for Medicare-covered lab services 0% to 10% of the cost for Medicare-covered diagnostic procedures and tests 10% of the cost for Medicare-covered X-rays 10% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)	**General** Authorization rules may apply. **In-Network** $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $30 to $125 copay for Medicare-covered X-rays $30 to $125 copay for Medicare-covered diagnostic radiology services (not including X-rays)	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 to $100 copay for Medicare-covered X-rays $20 to $100 copay for Medicare-covered diagnostic radiology services (not including X-rays) $0 copay for Medicare-covered therapeutic radiology services

	20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	0% of the cost for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% to 30% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 30% of the cost may apply 30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays 30% of the cost for diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 30% of the cost may apply	$0 copay for Medicare-covered therapeutic radiology services If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $20 to $30 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $20 to $30 may apply **Out-of-Network** 0% to 30% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 30% of the cost may apply 30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays 30% of the cost for diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 30% of the cost may apply	If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of $10 to $25 may apply If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of $10 to $25 may apply **Out-of-Network** 0% to 20% of the cost for diagnostic procedures, tests, and lab services If the doctor provides you services in addition to (Outpatient Diagnostic Procedures/Tests/Lab Services), separate cost sharing of 20% of the cost may apply 20% of the cost for therapeutic radiology services 20% of the cost for outpatient X-rays 20% of the cost for diagnostic radiology services If the doctor provides you services in addition to (Diagnostic Radiological Services, Therapeutic Radiological Services, Outpatient X-Rays), separate cost sharing of 20% of the cost may apply

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
22 - Cardiac and Pulmonary Rehabilitation Services	20% coinsurance Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Cardiac Rehabilitation Services 30% of the cost for Intensive Cardiac Rehabilitation Services 30% of the cost for Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 30% of the cost for Cardiac Rehabilitation Services 30% of the cost for Intensive Cardiac Rehabilitation Services 30% of the cost for Pulmonary Rehabilitation Services	**General** Authorization rules may apply. **In-Network** $0 copay for: • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** 20% of the cost for Cardiac Rehabilitation Services 20% of the cost for Intensive Cardiac Rehabilitation Services 20% of the cost for Pulmonary Rehabilitation Services
PREVENTIVE SERVICES				
23 - Preventive Services and Wellness/ Education Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing: • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)

	• Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk • HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.	• Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.	• Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.	• Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking) • Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
23 - Preventive Services and Wellness/ Education Programs *(continued)*	• Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	**In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 50% of the cost for supplemental education/wellness programs 0% of the cost for Medicare-covered preventive services	**In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/wellness programs	**In-Network** The plan covers the following supplemental education/wellness programs: • Health Club Membership/Fitness Classes **Out-of-Network** 0% of the cost for Medicare-covered preventive services 50% of the cost for supplemental education/wellness programs

	• Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.			
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** 10% of the cost for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 30% of the cost for renal dialysis	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 30% of the cost for renal dialysis	**In-Network** $0 copay for renal dialysis $0 copay for kidney disease education services **Out-of-Network** 0% of the cost for kidney disease education services 0% to 20% of the cost for renal dialysis
25 - Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 30% of the cost for Part B drugs out-of-network.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 30% of the cost for Part B drugs out-of-network.	**Drugs covered under Medicare Part B** **General** 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 0% to 20% of the cost for Part B drugs out-of-network.

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PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**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) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits.	**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) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits.	**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) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits.

		Your provider must get prior authorization from 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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and FreedomBlue PPO HD Rx (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930:	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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and FreedomBlue PPO Select (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930:	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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and FreedomBlue PPO Classic (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly drug costs reach $2,930:

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**Retail Pharmacy** **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier • $30 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $95 copay for a one-month (34-day) supply of drugs in this tier • $285 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	**Retail Pharmacy** **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier • $27 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. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $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.	**Retail Pharmacy** **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $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.

		Tier 4: Specialty Tier Drugs • 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** **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $25 copay for a one-month (34-day) supply of drugs in this tier • $25 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.	**Tier 4: Specialty Tier Drugs** • 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** **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $22.50 copay for a one-month (34-day) supply of drugs in this tier • $22.50 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.	**Tier 4: Specialty Tier Drugs** • 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** **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $42 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** **Tier 1: Generic Drugs** • $20 copay for a one-month (34-day) supply of drugs in this tier • $20 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.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $237.50 copay for a one-month (34-day) supply of drugs in this tier • $237.50 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. **Tier 4: Specialty Tier Drugs** • 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.	**Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $225 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. **Tier 4: Specialty Tier Drugs** • 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.	**Tier 2: Preferred Brand Drugs** • $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. **Tier 3: Non-Preferred Brand Drugs** • $225 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. **Tier 4: Specialty Tier Drugs** • 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 $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.

Catastrophic Coverage
After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of:
- 5% coinsurance, or

- $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.

Out-of-Network
Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from FreedomBlue PPO HD Rx (PPO).

Coverage Gap
After your total yearly drug costs reach $2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,700.

Catastrophic Coverage
After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of:
- 5% coinsurance, or

- $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs.

Out-of-Network
Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from FreedomBlue PPO Select (PPO).

Additional Coverage Gap
You pay the following:

Retail Pharmacy
Tier 1: Generic Drugs
- 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier

- 50% coinsurance 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
Tier 1: Generic Drugs
- 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier

Mail Order
Tier 1: Generic Drugs
- 50% coinsurance for a one-month (34-day) supply of all drugs covered in this tier

- 50% coinsurance 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.

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*		**Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $10 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $95 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.	**Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $9 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.	After your total yearly drug costs reach $2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,700. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from FreedomBlue PPO Classic (PPO).

		You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	**Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,930: **Tier 1: Generic Drugs** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $42 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Additional Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following: **Tier 1: Generic Drugs** • 50% coinsurance 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)
PREVENTIVE SERVICES				
25 - Outpatient Prescription Drugs *(continued)*				**Tier 2: Preferred Brand Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. **Tier 3: Non-Preferred Brand Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. **Tier 4: Specialty Tier Drugs** • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,700.

				You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.60 copay for generic (including brand drugs treated as generic) and a $6.50 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
26 - Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** 10% 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(s) every year	**General** Authorization rules may apply. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $30 to $150 copay for Medicare-covered dental benefits **Out-of-Network** 30% of the cost for comprehensive dental benefits	**General** Authorization rules may apply. **In-Network** $25 to $100 copay for Medicare-covered dental benefits • 30% of the cost for up to 1 oral exam(s) every six months • 30% of the cost for up to 1 cleaning(s) every six months • 30% of the cost for up to 1 dental x-ray(s) every year

For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call 1-800-550-8722, (TTY users 1-888-422-1226) and prospective members call 1-866-682-7969, (TTY users (711)).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
26 - 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.		**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.
27 - Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** $0 copay for hearing aids. • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	**In-Network** $0 copay for hearing aids. • $30 copay for Medicare-covered diagnostic hearing exams • $30 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 30% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.	**In-Network** $0 copay for hearing aids. • $25 copay for Medicare-covered diagnostic hearing exams • $25 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** 20% of the cost for hearing exams. 0% of the cost for hearing aids. **In and Out-of-Network** $500 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.

28 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of 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 • $0 to $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $10 to $25 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply	**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 • $0 to $30 copay for exams to diagnose and treat diseases and conditions of the eye. • $30 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $20 to $30 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 30% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply	**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 • $0 to $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 supplemental routine eye exam(s) every year If the doctor provides you services in addition to eye exams, separate cost sharing of $10 to $25 may apply $100 plan coverage limit for contact lenses every two years. $100 plan coverage limit for eye glass frames every two years. Plan offers additional vision benefits. Contact plan for details. **Out-of-Network** 0% to 20% of the cost for eye exams. If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 20% of the cost may apply

For questions about this plan's benefits or costs, please contact Highmark, Inc.
Current Members call 1-800-550-8722, (TTY users 1-888-422-1226) and prospective members call 1-866-682-7969, (TTY users (711)).

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO HD RX (PPO)	FREEDOMBLUE PPO SELECT (PPO)	FREEDOMBLUE PPO CLASSIC (PPO)
PREVENTIVE SERVICES				
28 - Vision Services *(continued)*		30% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.	30% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.	20% of the cost for eye wear. **In and Out-of-Network** $100 plan coverage limit for contact lenses every two years. This limit applies to both in-network and out-of-network benefits. $100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation *(Routine)*	Not covered.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.	**In-Network** $40 copay for each one-way trip to Plan-approved location. **Out-of-Network** 50% of the cost for transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.	**In-Network** This plan does not cover Acupuncture.

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