

FreedomBlueSM PPO

Central and Northeastern Pennsylvania



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January 1, 2012 through December 31, 2012

***FreedomBlue PPO Value (PPO), HD Rx (PPO),
BasicRx (PPO), Standard (PPO) and Deluxe (PPO)
January 1, 2012 - December 31, 2012***

CENTRAL AND NORTHEASTERN PA

Thank you for your interest in FreedomBlue PPO Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (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 Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

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

HOW CAN I COMPARE MY OPTIONS?

You can compare FreedomBlue PPO Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers. Our members receive

all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

***WHERE IS FREEDOMBLUE PPO VALUE (PPO),
HD RX (PPO), BASICRX (PPO), STANDARD
(PPO) AND DELUXE (PPO) AVAILABLE?***

The service area for this plan includes: Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, and York Counties, PA. You must live in one of these areas to join the plan.

There is more than one plan listed in this Summary of Benefits. 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 VALUE (PPO), HD RX (PPO), BASICRX
(PPO), STANDARD (PPO) AND DELUXE (PPO)?***

You can join FreedomBlue PPO Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in FreedomBlue PPO Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

FreedomBlue PPO Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO)

have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at www.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), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.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 Value (PPO) does cover Medicare Part B prescription drugs. FreedomBlue PPO Value (PPO) does NOT cover Medicare Part D prescription drugs.

FreedomBlue PPO HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

FreedomBlue PPO HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we

make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected 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.



FreedomBlue PPO

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 1-866-682-7971, (TTY users (711)).

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare 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 Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of FreedomBlue PPO HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a

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

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

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

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

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

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

- Osteoporosis Drugs: Injectable 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 Value (PPO), HD Rx (PPO), BasicRx (PPO), Standard (PPO) and Deluxe (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)-682-7971 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.



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 1-866-682-7971, (TTY users (711)).

SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
IMPORTANT INFORMATION			
<p>1 - Premium and Other Important Information</p>	<p>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.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>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.</p>	<p>General \$61 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>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.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>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.</p> <p>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.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General \$39 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>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.</p> <p>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.</p>	<p>General \$132 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>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.</p> <p>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.</p>	<p>General \$167 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>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.</p> <p>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.</p>

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 1-866-682-7971, (TTY users (711)).

SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
IMPORTANT INFORMATION			
<p>1 - Premium and Other Important Information (cont.)</p>		<p>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.</p> <p>In-Network \$3,400 out-of-pocket limit for Medicare-covered services.</p> <p>Out-of-Network \$500 annual deductible. Contact the plan for services that apply.</p> <p>In and Out-of-Network \$5,100 out-of-pocket limit for Medicare-covered services.</p>	<p>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.</p> <p>Highmark Inc. will reduce your monthly Medicare Part B premium by up to \$3.00.</p> <p>In-Network \$2,700 out-of-pocket limit for Medicare-covered services.</p> <p>In and Out-of-Network \$950 annual deductible. Contact the plan for services that apply.</p> <p>\$4,500 out-of-pocket limit for Medicare-covered services.</p>
<p>2 - Doctor and Hospital Choice (For more information, see <i>Emergency Care - #15</i> and <i>Urgently Needed Care - #16</i>.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>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.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>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.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>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.</p> <p>In-Network \$3,400 out-of-pocket limit for Medicare-covered services.</p> <p>Out-of-Network \$500 annual deductible. Contact the plan for services that apply.</p> <p>In and Out-of-Network \$5,100 out-of-pocket limit for Medicare-covered services.</p>	<p>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.</p> <p>In-Network \$3,400 out-of-pocket limit for Medicare-covered services.</p> <p>Out-of-Network \$500 annual deductible. Contact the plan for services that apply.</p> <p>In and Out-of-Network \$5,100 out-of-pocket limit for Medicare-covered services.</p>	<p>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.</p> <p>In-Network \$3,400 out-of-pocket limit for Medicare-covered services.</p> <p>Out-of-Network \$500 annual deductible. Contact the plan for services that apply.</p> <p>In and Out-of-Network \$5,100 out-of-pocket limit for Medicare-covered services.</p>
<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>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.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>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.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>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.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>

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 1-866-682-7971, (TTY users (711)).

SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
SUMMARY OF BENEFITS			
INPATIENT CARE			
<p>3 - Inpatient Hospital Care <i>(includes Substance Abuse and Rehabilitation Services)</i></p>	<p>In 2011 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1132 deductible</p> <p>Days 61 - 90: \$283 per day</p> <p>Days 91 - 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$350 copay for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 30% of the cost for each hospital stay.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>10% of the cost for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 30% of the cost for each hospital stay.</p>
<p>4 - Inpatient Mental Health Care</p>	<p>In 2011 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1132 deductible</p> <p>Days 61 - 90: \$283 per day</p> <p>Days 91 - 150: \$566 per lifetime reserve day</p> <p>These amounts may change for 2012.</p>	<p>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.</p> <p>\$350 copay for each Medicare-covered hospital stay.</p>	<p>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.</p> <p>10% of the cost for each Medicare-covered hospital stay.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$400 copay for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 30% of the cost for each hospital stay.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$200 copay for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>\$150 copay for each Medicare-covered hospital stay</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>
<p>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.</p> <p>\$400 copay for each Medicare-covered hospital stay.</p>	<p>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.</p> <p>\$200 copay for each Medicare-covered hospital stay.</p>	<p>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.</p> <p>\$150 copay for each Medicare-covered hospital stay.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
INPATIENT CARE			
4 - Inpatient Mental Health Care <i>(cont.)</i>	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.	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.	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.
5 - Skilled Nursing Facility (SNF) <i>(in a Medicare-certified skilled nursing facility)</i>	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. 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 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. 10% of the cost for each SNF stay. Out-of-Network 30% of the cost for each SNF stay.
6 - Home Health Care <i>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>	\$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

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 30% of the cost for each hospital stay.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>
<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 15: \$0 copay per day</p> <p>Days 16 - 75: \$75 copay per day</p> <p>Days 76 - 100: \$0 copay per day</p> <p>Out-of-Network 30% of the cost for each SNF stay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 15: \$0 copay per day</p> <p>Days 16 - 75: \$25 copay per day</p> <p>Days 76 - 100: \$0 copay per day</p> <p>Out-of-Network 20% of the cost for each SNF stay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 15: \$0 copay per day</p> <p>Days 16 - 75: \$25 copay per day</p> <p>Days 76 - 100: \$0 copay per day</p> <p>Out-of-Network 20% of the cost for each SNF stay.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network 30% of the cost for home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network 20% of the cost for home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network 20% of the cost for home health visits</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
INPATIENT CARE			
7 - Hospice	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>
OUTPATIENT CARE			
8 - Doctor Office Visits	20% coinsurance	<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$50 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network 30% of the cost for each primary care doctor visit</p> <p>30% of the cost for each specialist visit</p>	<p>In-Network \$5 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$50 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network 30% of the cost for each primary care doctor visit</p> <p>30% of the cost for each specialist visit</p>
9 - Chiropractic Services	<p>Supplemental routine care not covered</p> <p>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.</p>	<p>In-Network \$15 copay for each Medicare-covered visit</p> <p>\$15 copay for up to 8 supplemental routine visit(s) every year</p> <p>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.</p> <p>Out-of-Network 30% of the cost for chiropractic benefits.</p>	<p>In-Network \$5 copay for each Medicare-covered visit</p> <p>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.</p> <p>Out-of-Network 30% of the cost for chiropractic benefits.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>
<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$50 copay for each in-area, network urgent care Medicare-covered visit \$35 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network 30% of the cost for each primary care doctor visit 30% of the cost for each specialist visit</p>	<p>In-Network \$15 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.</p> <p>Out-of-Network 20% of the cost for each primary care doctor visit 20% of the cost for each specialist visit</p>	<p>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.</p> <p>Out-of-Network 20% of the cost for each primary care doctor visit 20% of the cost for each specialist visit</p>
<p>In-Network \$15 copay for each Medicare-covered visit \$15 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.</p> <p>Out-of-Network 30% of the cost for chiropractic benefits.</p>	<p>In-Network \$15 copay for each Medicare-covered visit \$15 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.</p> <p>Out-of-Network 20% of the cost for chiropractic benefits.</p>	<p>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.</p> <p>Out-of-Network 20% of the cost for chiropractic benefits.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT CARE			
<p>10 - Podiatry Services</p>	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>\$25 copay for up to 10 supplemental routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 30% of the cost for podiatry benefits.</p>	<p>In-Network 10% of the cost for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 30% of the cost for podiatry benefits.</p>
<p>11 - Outpatient Mental Health Care</p>	<p>40% coinsurance for most outpatient mental health services</p> <p>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.</p> <p>“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.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network 30% of the cost for Mental Health benefits with a psychiatrist</p> <p>30% of the cost for Mental Health benefits</p> <p>30% of the cost for partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for each Medicare-covered individual therapy visit</p> <p>10% of the cost for each Medicare-covered group therapy visit</p> <p>\$15 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$15 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>10% of the cost for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network 30% of the cost for Mental Health benefits with a psychiatrist</p> <p>30% of the cost for Mental Health benefits</p> <p>30% of the cost for partial hospitalization program services</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>In-Network \$35 copay for each Medicare-covered visit</p> <p>\$35 copay for up to 10 supplemental routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 30% of the cost for podiatry benefits.</p>	<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>\$25 copay for up to 10 supplemental routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>	<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>\$25 copay for up to 10 supplemental routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$35 copay for each Medicare-covered individual therapy visit</p> <p>\$35 copay for each Medicare-covered group therapy visit</p> <p>\$35 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$35 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network 30% of the cost for Mental Health benefits with a psychiatrist</p> <p>30% of the cost for Mental Health benefits</p> <p>30% of the cost for partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network 20% of the cost for Mental Health benefits with a psychiatrist</p> <p>20% of the cost for Mental Health benefits</p> <p>20% of the cost for partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$0 copay for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network 20% of the cost for Mental Health benefits with a psychiatrist</p> <p>20% of the cost for Mental Health benefits</p> <p>20% of the cost for partial hospitalization program services</p>

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SECTION TWO: SUMMARY OF BENEFITS

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

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$35 copay for Medicare-covered individual visits</p> <p>\$35 copay for Medicare-covered group visits</p> <p>Out-of-Network 30% of the cost for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual visits</p> <p>\$25 copay for Medicare-covered group visits</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered individual visits</p> <p>\$25 copay for Medicare-covered group visits</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$200 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network 30% of the cost for outpatient hospital facility benefits.</p> <p>30% of the cost for ambulatory surgical center benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$100 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network 20% of the cost for outpatient hospital facility benefits.</p> <p>20% of the cost for ambulatory surgical center benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$50 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$50 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network 20% of the cost for outpatient hospital facility benefits.</p> <p>20% of the cost for ambulatory surgical center benefits.</p>
<p>In-Network \$125 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$125 copay [or 30% of the cost] for ambulance benefits.</p>	<p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$100 copay [or 20% of the cost] for ambulance benefits.</p>	<p>In-Network \$75 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$75 copay [or 20% of the cost] for ambulance benefits.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT CARE			
<p>15 - Emergency Care <i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i></p>	<p>20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>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.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p>
<p>16 - Urgently Needed Care <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i></p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>
<p>17 - Outpatient Rehabilitation Services <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i></p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network 30% of the cost for Physical and/or Speech and Language Therapy visits</p> <p>30% of the cost for Occupational Therapy benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered Occupational Therapy visits</p> <p>10% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network 30% of the cost for Physical and/or Speech and Language Therapy visits</p> <p>30% of the cost for Occupational Therapy benefits.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p>
<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$35 copay for Medicare-covered Occupational Therapy visits</p> <p>\$35 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network 30% of the cost for Physical and/or Speech and Language Therapy visits</p> <p>30% of the cost for Occupational Therapy benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network 20% of the cost for Physical and/or Speech and Language Therapy visits</p> <p>20% of the cost for Occupational Therapy benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network 20% of the cost for Physical and/or Speech and Language Therapy visits</p> <p>20% of the cost for Occupational Therapy benefits.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment <i>(includes wheelchairs, oxygen, etc.)</i>	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 0% to 50% of the cost for durable medical equipment</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered items</p> <p>Out-of-Network 0% to 50% of the cost for durable medical equipment</p>
19 - Prosthetic Devices <i>(includes braces, artificial limbs and eyes, etc.)</i>	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 50% of the cost for prosthetic devices.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered items</p> <p>Out-of-Network 50% of the cost for prosthetic devices.</p>
20 - Diabetes Programs and Supplies	<p>20% coinsurance for diabetes self-management training</p> <p>20% coinsurance for diabetes supplies</p> <p>20% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>0% to 20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p> <p>If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$15 to \$25 may apply</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Diabetes monitoring supplies • Therapeutic shoes or inserts <p>If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$5 to \$15 may apply</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 0% to 50% of the cost for durable medical equipment</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 0% to 50% of the cost for durable medical equipment</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 0% to 50% of the cost for durable medical equipment</p>
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 50% of the cost for prosthetic devices.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 50% of the cost for prosthetic devices.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 50% of the cost for prosthetic devices.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>0% to 20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p> <p>If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$15 to \$35 may apply</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>0% to 20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p> <p>If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$15 to \$25 may apply</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>0% to 20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p> <p>If the doctor provides you services in addition to Diabetes self-management training, separate cost sharing of \$10 to \$25 may apply</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
20 - Diabetes Programs and Supplies <i>(cont.)</i>		<p>Out-of-Network 0% of the cost for Diabetes self-management training</p> <p>If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>50% of the cost for Diabetes monitoring supplies</p> <p>50% of the cost for Therapeutic shoes or inserts</p>	<p>Out-of-Network 0% of the cost for Diabetes self-management training</p> <p>If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>50% of the cost for Diabetes monitoring supplies</p> <p>50% of the cost for Therapeutic shoes or inserts</p>
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>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.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$20 copay for Medicare-covered lab services</p> <p>\$0 to \$20 copay for Medicare-covered diagnostic procedures and tests</p> <p>\$30 to \$125 copay for Medicare-covered X-rays</p> <p>\$30 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>\$0 copay for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% to 10% of the cost for Medicare-covered lab services</p> <p>0% to 10% of the cost for Medicare-covered diagnostic procedures and tests</p> <p>10% of the cost for Medicare-covered X-rays</p> <p>10% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Out-of-Network 0% of the cost for Diabetes self-management training</p> <p>If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>50% of the cost for Diabetes monitoring supplies</p> <p>50% of the cost for Therapeutic shoes or inserts</p>	<p>Out-of-Network 0% of the cost for Diabetes self-management training</p> <p>If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply</p> <p>50% of the cost for Diabetes monitoring supplies</p> <p>50% of the cost for Therapeutic shoes or inserts</p>	<p>Out-of-Network 0% of the cost for Diabetes self-management training</p> <p>If the doctor provides you services in addition to (Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply</p> <p>50% of the cost for Diabetes monitoring supplies</p> <p>50% of the cost for Therapeutic shoes or inserts</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$20 copay for Medicare-covered lab services</p> <p>\$0 to \$20 copay for Medicare-covered diagnostic procedures and tests</p> <p>\$30 to \$125 copay for Medicare-covered X-rays</p> <p>\$30 to \$125 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>\$0 copay for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests <p>\$20 to \$75 copay for Medicare-covered X-rays</p> <p>\$20 to \$75 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>\$0 copay for Medicare-covered therapeutic radiology services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests <p>\$10 to \$50 copay for Medicare-covered X-rays</p> <p>\$10 to \$50 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>\$0 copay for Medicare-covered therapeutic radiology services</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services (cont.)</p>	<p>20% coinsurance for digital rectal exam and other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$15 to \$25 may apply</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$15 to \$25 may apply</p> <p>Out-of-Network 0% to 30% of the cost for diagnostic procedures, tests, and lab services</p> <p>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</p> <p>30% of the cost for therapeutic radiology services</p> <p>30% of the cost for outpatient X-rays</p> <p>30% of the cost for diagnostic radiology services</p> <p>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</p>	<p>0% of the cost for Medicare-covered therapeutic radiology services</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$5 to \$15 may apply</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$5 to \$15 may apply</p> <p>Out-of-Network 0% to 30% of the cost for diagnostic procedures, tests, and lab services</p> <p>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</p> <p>30% of the cost for therapeutic radiology services</p> <p>30% of the cost for outpatient X-rays</p> <p>30% of the cost for diagnostic radiology services</p> <p>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</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$15 to \$35 may apply</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$15 to \$35 may apply</p> <p>Out-of-Network 0% to 30% of the cost for diagnostic procedures, tests, and lab services</p> <p>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</p> <p>30% of the cost for therapeutic radiology services</p> <p>30% of the cost for outpatient X-rays</p> <p>30% of the cost for diagnostic radiology services</p> <p>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</p>	<p>If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of \$15 to \$25 may apply</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$15 to \$25 may apply</p> <p>Out-of-Network 0% to 20% of the cost for diagnostic procedures, tests, and lab services</p> <p>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</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient X-rays</p> <p>20% of the cost for diagnostic radiology services</p> <p>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</p>	<p>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</p> <p>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of \$10 to \$25 may apply</p> <p>Out-of-Network 0% to 20% of the cost for diagnostic procedures, tests, and lab services</p> <p>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</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for outpatient X-rays</p> <p>20% of the cost for diagnostic radiology services</p> <p>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</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
22 - Cardiac and Pulmonary Rehabilitation Services	<p>20% coinsurance Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services <p>Out-of-Network 30% of the cost for Cardiac Rehabilitation Services</p> <p>30% of the cost for Intensive Cardiac Rehabilitation Services</p> <p>30% of the cost for Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services <p>Out-of-Network 30% of the cost for Cardiac Rehabilitation Services</p> <p>30% of the cost for Intensive Cardiac Rehabilitation Services</p> <p>30% of the cost for Pulmonary Rehabilitation Services</p>
PREVENTIVE SERVICES			
23 - Preventive Services and Wellness/ Education Programs	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> • 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. 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services <p>Out-of-Network 30% of the cost for Cardiac Rehabilitation Services</p> <p>30% of the cost for Intensive Cardiac Rehabilitation Services</p> <p>30% of the cost for Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services <p>Out-of-Network 20% of the cost for Cardiac Rehabilitation Services</p> <p>20% of the cost for Intensive Cardiac Rehabilitation Services</p> <p>20% of the cost for Pulmonary Rehabilitation Services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> • Medicare-covered Cardiac Rehabilitation Services • Medicare-covered Intensive Cardiac Rehabilitation Services • Medicare-covered Pulmonary Rehabilitation Services <p>Out-of-Network 20% of the cost for Cardiac Rehabilitation Services</p> <p>20% of the cost for Intensive Cardiac Rehabilitation Services</p> <p>20% of the cost for Pulmonary Rehabilitation Services</p>
<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening 	<p>General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
<p>23 - Preventive Services and Wellness/ Education Programs (cont.)</p>	<ul style="list-style-type: none"> • 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. • 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 	<ul style="list-style-type: none"> • 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) <p>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.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Health Club Membership/Fitness Classes 	<ul style="list-style-type: none"> • 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) <p>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.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Health Club Membership/Fitness Classes

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<ul style="list-style-type: none"> • 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) <p>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.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Health Club Membership/Fitness Classes 	<ul style="list-style-type: none"> • 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) <p>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.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Health Club Membership/Fitness Classes 	<ul style="list-style-type: none"> • 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) <p>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.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Health Club Membership/Fitness Classes

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
23 - Preventive Services and Wellness/ Education Programs <i>(cont.)</i>	<ul style="list-style-type: none"> • 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. • 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. 	<p>Out-of-Network If the doctor provides you services in addition to (Supplemental Preventive Health Services, Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>0% of the cost for Medicare-covered preventive services</p> <p>50% of the cost for supplemental education/wellness programs</p>	<p>Out-of-Network If the doctor provides you services in addition to (Supplemental Preventive Health Services, Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>50% of the cost for supplemental education/wellness programs</p> <p>0% of the cost for Medicare-covered preventive services</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Out-of-Network If the doctor provides you services in addition to (Supplemental Preventive Health Services, Diabetes Self-Management Training), separate cost sharing of 30% of the cost may apply</p> <p>0% of the cost for Medicare-covered preventive services</p> <p>50% of the cost for supplemental education/wellness programs</p>	<p>Out-of-Network If the doctor provides you services in addition to (Supplemental Preventive Health Services, Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply</p> <p>0% of the cost for Medicare-covered preventive services</p> <p>50% of the cost for supplemental education/wellness programs</p>	<p>Out-of-Network If the doctor provides you services in addition to (Supplemental Preventive Health Services, Diabetes Self-Management Training), separate cost sharing of 20% of the cost may apply</p> <p>0% of the cost for Medicare-covered preventive services</p> <p>50% of the cost for supplemental education/wellness programs</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
24 - Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	<p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network 0% of the cost for kidney disease education services</p> <p>0% to 30% of the cost for renal dialysis</p>	<p>In-Network 10% of the cost for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network 0% of the cost for kidney disease education services</p> <p>0% to 30% of the cost for renal dialysis</p>
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.	<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered.</p> <p>0% to 15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>0% to 30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 0% to 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>0% to 30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network 0% of the cost for kidney disease education services</p> <p>0% to 30% of the cost for renal dialysis</p>	<p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network 0% of the cost for kidney disease education services</p> <p>0% to 20% of the cost for renal dialysis</p>	<p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network 0% of the cost for kidney disease education services</p> <p>0% to 20% of the cost for renal dialysis</p>
<p>Drugs covered under Medicare Part B</p> <p>General 0% to 15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>0% to 30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. 	<p>Drugs covered under Medicare Part B</p> <p>General 0% to 15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>0% to 20% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. 	<p>Drugs covered under Medicare Part B</p> <p>General 0% to 15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>0% to 20% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers.

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs <i>(cont.)</i>			<p>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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from FreedomBlue PPO HD Rx (PPO) for certain drugs.</p> <p>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.</p> <p>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.</p> <p>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.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from FreedomBlue PPO Basic Rx (PPO) for certain drugs.</p> <p>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.</p> <p>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.</p> <p>If you request a formulary exception for a drug and FreedomBlue PPO Basic Rx (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>	<p>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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from FreedomBlue PPO Standard (PPO) for certain drugs.</p> <p>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.</p> <p>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.</p> <p>If you request a formulary exception for a drug and FreedomBlue PPO Standard (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>	<p>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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from FreedomBlue PPO Deluxe (PPO) for certain drugs.</p> <p>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.</p> <p>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.</p> <p>If you request a formulary exception for a drug and FreedomBlue PPO Deluxe (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 	<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 	<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs <i>(cont.)</i>			<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$95 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$95 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier 	<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$90 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier 	<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$42 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$90 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			<p>Mail Order</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Mail Order Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p>Mail Order Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p>Mail Order Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs <i>(cont.)</i>			<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>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.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>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.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. 	<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>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.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. 	<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 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 <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Additional Coverage Gap You pay the following:</p> <p>Retail Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of all drugs covered in this tier • \$24 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of all drugs covered in this tier

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			<p>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).</p> <p>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:</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$95 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>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 Basic Rx (PPO).</p> <p>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:</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$95 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier 	<p>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 Standard (PPO).</p> <p>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:</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$45 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$90 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier 	<p>Mail Order Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$20 copay for a one-month (34-day) supply of all drugs covered in this tier • \$20 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>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.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			<p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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.</p> <p>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.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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.</p> <p>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.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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.</p> <p>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.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>	<p>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 Deluxe (PPO).</p> <p>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:</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$42 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$90 copay for a one-month (34-day) supply of drugs in this tier

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
		<p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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:</p> <p>Tier 1: Generic Drugs</p> <ul style="list-style-type: none"> • \$8 copay for a one-month (34-day) supply of all drugs covered in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • 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.

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
25 - Outpatient Prescription Drugs (cont.)			

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
		<p>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.</p> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p> <p>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:</p> <ul style="list-style-type: none"> 5% coinsurance, or \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
<p>26 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 to \$100 copay for Medicare-covered dental benefits</p> <p>Out-of-Network 30% of the cost for comprehensive dental benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network 10% of the cost for Medicare-covered dental benefits</p> <ul style="list-style-type: none"> • 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 <p>Out-of-Network 50% of the cost for preventive dental benefits</p> <p>30% to 50% of the cost for comprehensive dental benefits</p> <p>In and Out-of-Network Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.</p>
<p>27 - Hearing Services</p>	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$25 copay for Medicare-covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hearing exam(s) every year <p>Out-of-Network 30% of the cost for hearing exams.</p> <p>0% of the cost for hearing aids.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$15 copay for Medicare-covered diagnostic hearing exams • \$15 copay for up to 1 supplemental routine hearing exam(s) every year <p>Out-of-Network 30% of the cost for hearing exams.</p> <p>0% of the cost for hearing aids.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$35 to \$200 copay for Medicare-covered dental benefits</p> <p>Out-of-Network 30% of the cost for comprehensive dental benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 to \$100 copay for Medicare-covered dental benefits</p> <p>Out-of-Network 20% of the cost for comprehensive dental benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 to \$50 copay for Medicare-covered dental benefits</p> <ul style="list-style-type: none"> • 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 <p>Out-of-Network 50% of the cost for preventive dental benefits</p> <p>20% to 50% of the cost for comprehensive dental benefits</p> <p>In and Out-of-Network Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.</p>
<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$35 copay for Medicare-covered diagnostic hearing exams • \$35 copay for up to 1 supplemental routine hearing exam(s) every year <p>Out-of-Network 30% of the cost for hearing exams. 0% of the cost for hearing aids.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$25 copay for Medicare-covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hearing exam(s) every year <p>Out-of-Network 20% of the cost for hearing exams. 0% of the cost for hearing aids.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> • \$25 copay for Medicare-covered diagnostic hearing exams • \$25 copay for up to 1 supplemental routine hearing exam(s) every year <p>Out-of-Network 20% of the cost for hearing exams. 0% of the cost for hearing aids.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
27 - Hearing Services <i>(cont.)</i>		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 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	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • 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 <p>If the doctor provides you services in addition to eye exams, separate cost sharing of \$15 to \$25 may apply</p> <p>\$100 plan coverage limit for contact lenses every two years.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p> <p>Plan offers additional vision benefits. Contact plan for details.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • 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 \$15 copay for exams to diagnose and treat diseases and conditions of the eye. • \$15 copay for up to 1 supplemental routine eye exam(s) every year <p>If the doctor provides you services in addition to eye exams, separate cost sharing of \$5 to \$15 may apply</p> <p>\$100 plan coverage limit for contact lenses every two years.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p> <p>Plan offers additional vision benefits. Contact plan for details.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>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.</p>	<p>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.</p>	<p>In and Out-of-Network \$1,000 plan coverage limit for supplemental routine hearing aids every three years. This limit applies to both in-network and out-of-network benefits.</p>
<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • 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 \$35 copay for exams to diagnose and treat diseases and conditions of the eye. • \$35 copay for up to 1 supplemental routine eye exam(s) every year <p>If the doctor provides you services in addition to eye exams, separate cost sharing of \$15 to \$35 may apply</p> <p>\$100 plan coverage limit for contact lenses every two years.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p> <p>Plan offers additional vision benefits. Contact plan for details.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • 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 <p>If the doctor provides you services in addition to eye exams, separate cost sharing of \$15 to \$25 may apply</p> <p>\$100 plan coverage limit for contact lenses every two years.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p> <p>Plan offers additional vision benefits. Contact plan for details.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • 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 <p>If the doctor provides you services in addition to eye exams, separate cost sharing of \$10 to \$25 may apply</p> <p>\$100 plan coverage limit for contact lenses every two years.</p> <p>\$100 plan coverage limit for eye glass frames every two years.</p> <p>Plan offers additional vision benefits. Contact plan for details.</p>

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SECTION TWO: SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	FREEDOMBLUE PPO VALUE (PPO)	FREEDOMBLUE PPO HD RX (PPO)
PREVENTIVE SERVICES			
28 - Vision Services <i>(cont.)</i>		<p>Out-of-Network 0% to 30% of the cost for eye exams.</p> <p>If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply</p> <p>30% of the cost for eye wear.</p> <p>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.</p> <p>\$100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.</p>	<p>Out-of-Network 0% to 30% of the cost for eye exams.</p> <p>If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply</p> <p>30% of the cost for eye wear.</p> <p>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.</p> <p>\$100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.</p>
Over-the-Counter Items	Not covered.	<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>
Transportation <i>(Routine)</i>	Not covered.	<p>In-Network \$40 copay for each one-way trip to Plan-approved location.</p> <p>Out-of-Network 50% of the cost for transportation.</p>	<p>In-Network \$40 copay for each one-way trip to Plan-approved location.</p> <p>Out-of-Network 50% of the cost for transportation.</p>
Acupuncture	Not covered.	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

FREEDOMBLUE PPO BASIC RX (PPO)	FREEDOMBLUE PPO STANDARD (PPO)	FREEDOMBLUE PPO DELUXE (PPO)
<p>Out-of-Network 0% to 30% of the cost for eye exams.</p> <p>If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 30% of the cost may apply</p> <p>30% of the cost for eye wear.</p> <p>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.</p> <p>\$100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.</p>	<p>Out-of-Network 0% to 20% of the cost for eye exams.</p> <p>If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 20% of the cost may apply</p> <p>20% of the cost for eye wear.</p> <p>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.</p> <p>\$100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.</p>	<p>Out-of-Network 0% to 20% of the cost for eye exams.</p> <p>If the doctor provides you services in addition to (Eye Exams), separate cost sharing of 20% of the cost may apply</p> <p>20% of the cost for eye wear.</p> <p>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.</p> <p>\$100 plan coverage limit for eye glass frames every two years. This limit applies to both in-network and out-of-network benefits.</p>
<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>
<p>In-Network \$40 copay for each one-way trip to Plan-approved location.</p> <p>Out-of-Network 50% of the cost for transportation.</p>	<p>In-Network \$40 copay for each one-way trip to Plan-approved location.</p> <p>Out-of-Network 50% of the cost for transportation.</p>	<p>In-Network \$40 copay for each one-way trip to Plan-approved location.</p> <p>Out-of-Network 50% of the cost for transportation.</p>
<p>In-Network This plan does not cover Acupuncture</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

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 1-866-682-7971, (TTY users (711)).



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