<table>
<thead>
<tr>
<th>HEALTH</th>
<th>Freedom Blue PPO Basic</th>
<th>Freedom Blue PPO Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In Network</strong></td>
<td><strong>Out Of Network</strong></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$250</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>10% 20%</td>
<td>0% 20%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$1,000 $3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td><strong>Annual Physical Exam</strong></td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Screenings &amp; Exams</strong></td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td>(Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate &amp; Bone Mass Measurement)</td>
<td>Covered in Full</td>
<td>Covered in Full</td>
</tr>
<tr>
<td><strong>Doctor Office Visit</strong></td>
<td>$15 cost sharing</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$20 cost sharing</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>X-ray or Radiology</strong></td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Facility Services</td>
<td>Freedom Blue PPO Basic</td>
<td>Freedom Blue PPO Standard</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>10% coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>10% coinsurance</td>
<td>$50</td>
</tr>
<tr>
<td>Emergency Room Services (Worldwide Coverage)</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Urgently Needed Care (this is NOT emergency care)</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Inpatient Hospital Stay</td>
<td>10% coinsurance</td>
<td>$50</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care (100 days per Medicare benefit period)</td>
<td>10% coinsurance</td>
<td>$25 days 16-55</td>
</tr>
<tr>
<td>Annual Routine Vision Exam (Includes refraction)</td>
<td>$0</td>
<td>$0 cost sharing</td>
</tr>
<tr>
<td>Eyeglasses or Contact Lenses (Covered every year)</td>
<td>Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames and a $100 benefit maximum for specialty contact lenses.</td>
<td>You have a $100 benefit maximum for out-of-network specialty frames or specialty contact lenses.</td>
</tr>
<tr>
<td>Annual Routine Hearing Exam</td>
<td>$20 cost sharing</td>
<td>$20 cost sharing</td>
</tr>
<tr>
<td>Service Type</td>
<td>Freedom Blue PPO Basic In Network</td>
<td>Freedom Blue PPO Basic Out Of Network</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Hearing Aids (covered every three years)</td>
<td>$500 coverage</td>
<td>$500 coverage</td>
</tr>
<tr>
<td>Chiropractic Office Visits</td>
<td>$20 cost sharing</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Home Health</td>
<td>You pay cost sharing of 10% for Medicare-covered home health services</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Physical, Speech and Occupational Therapy (per visit/per day/per provider)</td>
<td>$20 cost sharing</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Part B Drugs</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Ambulance (Emergent Services per one way trip)</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)</td>
<td>10% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>
### Mental Health Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Freedom Blue PPO Basic</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out Of Network</td>
</tr>
<tr>
<td>Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)</td>
<td>$20 cost sharing</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

### Drugs

#### Part D Drugs (Up to 31-Day Retail Supply)

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Freedom Blue PPO Basic</th>
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</tr>
</thead>
</table>
| Initial Coverage Period (up to $3,700 in total drug costs) | Tier 1 (Pref. Generic) - $15  
Tier 2 (Non-Pref. Generic) - $15  
Tier 3 (Pref. Brand & Generic) - $35  
Tier 4 (Non-Pref. Brand & Generic) - $70  
Tier 5 (Specialty) – 33% | Tier 1 (Pref. Generic) - $15  
Tier 2 (Non-Pref. Generic) - $15  
Tier 3 (Pref. Brand & Generic) - $35  
Tier 4 (Non-Pref. Brand & Generic) - $70  
Tier 5 (Specialty) - $70 |
| Coverage Gap Period (from $3,700.01 in total drug costs to $4,950 in yearly out-of-pocket drug costs) | Tier 1 (Pref. Generic) - $15  
Tier 2 (Non-Pref. Generic) - $15  
Tier 3 (Pref. Brand & Generic) - $35  
Tier 4 (Non-Pref. Brand & Generic) - $70  
Tier 5 (Specialty) – 33% | Tier 1 (Pref. Generic) - $15  
Tier 2 (Non-Pref. Generic) - $15  
Tier 3 (Pref. Brand & Generic) - $35  
Tier 4 (Non-Pref. Brand & Generic) - $70  
Tier 5 (Specialty) - $70 |
| Catastrophic Coverage Period (after $4,950.01 in total out-of-pocket drug costs) | The greater of 5% or $3.30 for generic or multi-source drugs or $8.25 for all other drugs | The greater of 5% or $3.30 for generic or multi-source drugs or $8.25 for all other drugs |
| Mail Order (up to 90-day supply, Specialty Drug up to 31-day supply) | Tier 1 (Pref. Generic) - $30  
Tier 2 (Non-Pref. Generic) - $30  
Tier 3 (Pref. Brand & Generic) - $70  
Tier 4 (Non-Pref. Brand & Generic) - $140  
Tier 5 (Specialty) – 33% | Tier 1 (Pref. Generic) - $30  
Tier 2 (Non-Pref. Generic) - $30  
Tier 3 (Pref. Brand & Generic) - $70  
Tier 4 (Non-Pref. Brand & Generic) - $140  
Tier 5 (Specialty) - $140 |

### Additional Information

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.
This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Highmark Blue Cross Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross and Blue Shield Association.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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

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

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

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).
Reference Code (Please have this number ready when you call): 17FB8452, 17FB8453