2020 Benefit Summary

University of Pittsburgh		178452 **Freedom Blue PPO Basic Option**	178453 **Freedom Blue PPO Standard Option**
HEALTH	Deductible	$250	$0
		In Network/Out of Network	**In Network/Out of Network**
	Out-of-Pocket Maximum	$1,000 / $3,400	$3,400 / $3,400
	Annual Physical Exam	Covered in Full	Covered in Full
	Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
	Doctor Office Visit	$15 / $15	$15 / $15
	Specialist Office Visit	$20 / $20	$20 / $20
	X-ray or Radiology	10% / 10%	0% / 0%
	Diagnostic Testing	10% / 10%	0% / 0%
	Outpatient Surgery	10% / 10%	0% / 0%
	Emergency Room Services (Worldwide Coverage)	$50	$50

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Urgently Needed Care (this is NOT emergency care)	$40	$40
Inpatient Hospital Stay	10% / 10% per stay	$50 / $50 per stay
Skilled Nursing Facility Care (100 days per Medicare benefit period)	10% / 10%	$25 days 16-55 / $25 days 16-55
Annual Routine Vision Exam (Includes refraction)	$0 / $50 copay for eye exam	$0 / $50 copay for eye exam
Eyeglasses or Contact Lenses (Covered every year)	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. / $100 benefit maximum	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./ $100 benefit maximum
Annual Routine Hearing Exam	$20 / $20	$20 / $20
Hearing Aids	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing / $500 allowance for hearing aids every 3 years from any other provider	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing / $500 allowance for hearing aids every 3 years from any other provider
Home Health	10% / 10%	0% / 0%

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Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$20 / $20	$20 / $20
Part B Drugs	10% / 10%	10% up to $300 Qtr max / 10% up to $300 Qtr max
Ambulance (Emergent Services per one way trip)	10%	$25
Ambulance (Non-Emergent) Services per one way trip	10% / 20%	$25 / 20%
Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	10% / 20%	15% / 20%
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	10% / 10% per stay	$50 / $50 per stay
Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$20 / $20	$20 / $20

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DRUGS	PART D DRUGS UP TO 31 DAY RETAIL SUPPLY	Initial Coverage Period **Preferred Retail** (up to $4,019.99 in total drug costs)	$10 Pref. Generic $10 Generic $30 Preferred Brand $65 Non-Pref. Brand 33% Specialty	$10 Pref. Generic $10 Generic $30 Preferred Brand $65 Non-Pref. Brand $70 Specialty
		Initial Coverage Period Standard Retail (up to $4,019.99 in total drug costs)	$15 Pref. Generic $15 Generic $35 Preferred Brand $70 Non-Pref. Brand 33% Specialty	$15 Pref. Generic $15 Generic $35 Preferred Brand $70 Non-Pref. Brand $70 Specialty
		Coverage Gap Period **Preferred Retail** (from $4,020 in total drug costs to $6,349.99 in yearly out-of-pocket drug costs)	$10 Pref. Generic $10 Generic $30 Preferred Brand $65 Non-Pref. Brand 33% Specialty	$10 Pref. Generic $10 Generic $30 Preferred Brand $65 Non-Pref. Brand $70 Specialty
		Coverage Gap Period Standard Retail (from $4,020 in total drug costs to $6,349.99 in yearly out-of-pocket drug costs)	$15 Pref. Generic $15 Generic $35 Preferred Brand $70 Non-Pref. Brand 33% Specialty	$15 Pref. Generic $15 Generic $35 Preferred Brand $70 Non-Pref. Brand $70 Specialty
		Catastrophic Coverage Period (after $6,350 in total out-of-pocket drug costs)	The greater of 5% or $3.60 for generic or multi-source drugs or $8.95 for all other drugs	The greater of 5% or $3.60 for generic or multi-source drugs or $8.95 for all other drugs
		Mail Order (up to 90-day supply, Specialty Drug up to 31-day supply)	2 times preferred retail copay	2 times preferred retail copay

- 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 is a registered mark of Highmark Inc. Highmark Senior Health Company is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 (TTY users call 711)

Reference Code (Please have this number ready when you call): **20FB178452**– Basic Option, **20FB178453** – Standard Option

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