This is only a summary of your plan's benefits. See your Evidence of Coverage for more detailed information.

HIGHMARK®

2019 Benefits Summary

Lafayette College 178322	Freedom Blue PPO	
	In Network	Out Of Network
Deductible	$800	
In Network Member Out-of-Pocket Maximum (For Medicare-covered services, not including Part D drugs)	$1,600	N/A
Combined In and Out-of-Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)	$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 copay	30% Coinsurance
Specialist Office Visit	$25 copay	30% Coinsurance
Advanced Imaging (Examples: CT Scans, MRI)	15% Coinsurance	30% Coinsurance
Standard Imaging (Examples: X-ray, Mammogram)	15% Coinsurance	30% Coinsurance
Diagnostic Testing (Example: Blood Work)	15% Coinsurance	30% Coinsurance
Outpatient Surgery	15% Coinsurance	30% Coinsurance
Emergency Room Services (Worldwide Coverage)	$75 copay	$75 copay
Urgently Needed Care	$40 copay	$40 copay
Inpatient Hospital or Long-Term Acute Care Facility Stay	15% Coinsurance per admission	30% Coinsurance per admission
Skilled Nursing Facility Care (100 days per Medicare benefit period)	15% Coinsurance per admission	30% Coinsurance per admission
Annual Routine Vision Exam (includes refraction)	$0 copay	$50 copay

[1] You must continue to pay your Medicare Part B premium.

	Lafayette College 178322	Freedom Blue PPO	
		In Network	Out Of Network
HEALTH	Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. $100 benefit maximum applies to non-standard frames and $100 benefit maximum for specialty contact lenses.	$100 benefit maximum
	Annual Routine Hearing Exam	• $25 copay	30% Coinsurance
	Hearing Aids (In-network covered every year)	• $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	15% copay for Medicare-covered home health services	30% copay for Medicare-covered home health services
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$25 copay	30% Coinsurance
	Renal Dialysis	$0 copay	30% Coinsurance
	Part B Drugs	15% coinsurance	30% Coinsurance
	Ambulance (Emergent Services per one way trip)	15% Coinsurance	15% Coinsurance
	Ambulance (Non-Emergent per one way trip)	15% Coinsurance	30% Coinsurance
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)	15% coinsurance	30% Coinsurance
	Oxygen/Oxygen Supplies	15% coinsurance	30% Coinsurance
	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	15% Coinsurance per admission	30% Coinsurance per admission

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Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$25 copay	30% Coinsurance

PART D DRUGS

You pay the following until your total yearly drug costs reaches $3,820 Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.

Deductible			$250
Initial Coverage	Retail Cost Sharing	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	$15 copay
		Tier 2 (Generic)	$15 copay
		Tier 3 (Preferred Brand)	$30 copay
		Tier 4 (Non-Preferred Drug)	$60 copay
		Tier 5 (Specialty)	$60 copay
	Mail Order Cost Sharing	Tier	Up to 90 Day Supply
		Tier 1 (Preferred Generic)	$37.50 copay
		Tier 2 (Generic)	$37.50 copay
		Tier 3 (Preferred Brand)	$75 copay
		Tier 4 (Non-Preferred Drug)	$150 copay
		Tier 5 (Specialty)	Not Available

The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.01 until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Coverage Gap	Retail Cost Sharing	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	$15 copay
		Tier 2 (Generic)	$15 copay
		Tier 3 (Preferred Brand)	$30 copay
		Tier 4 (Non-Preferred Drugs)	$60 copay
		Tier 5 (Specialty)	$60 copay
	Mail Order Cost Sharing	Tier	Up to 90 Day Supply
		Tier 1 (Preferred Generic)	$37.50 copay
		Tier 2 (Generic)	$37.50 copay
		Tier 3 (Preferred Brand)	$75 copay

		Tier 4 (Non-Preferred Drugs)	$150 copay
		Tier 5 (Specialty)	Not Available

Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $5,100.01, you pay the greater of: 5% of the cost, or a $3.40 copay for generics and a $8.50 copay for all other drugs.	
Catastrophic Coverage	Greater of: 5% or $3.40 Generic/Preferred Multi-Source or $8.50 for all others.

Highmark Senior Health Company and Highmark Senior Solutions Company are PPO plans with a Medicare contract. Enrollment in Highmark Senior Health Company and Highmark Senior Solutions Company depend on contract renewal.

Highmark Blue Shield, Highmark Senior Health Company, and Highmark Senior Solutions are independent licensees of the Blue Cross and Blue Shield Association.

You must continue to pay your Medicare Part B premium. 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 provider network may change at any time. You will receive notice when necessary. 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 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): 19FB8322

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