



**Medicare Advantage
2025 Benefit Summary**

Name: Lafayette College-0178322

	Freedom Blue PPO (PA) PPO	
Medical Benefits	In-Network	Out-of-Network
Deductible	\$800	
Coinsurance (see specific benefits for cost sharing)	15%	30%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	\$1,600	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	\$3,400	
Physician and other Health Professional Services	In-Network	Out-of-Network
Office Visits - Primary Doctor	\$15	30%
Office Visits - Specialist	\$25	30%
Radiation Therapy	0%	30%
Emergency Room (waived if admitted within 3 days)	\$75	
Urgent Care	\$40	
Ambulance (Emergent)	15%	
Ambulance (Non-Emergent)	15%	30%
Routine Transportation Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	\$10	50%
More than 20 Preventive Services	In-Network	Out-of-Network
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	In-Network	Out-of-Network
Hospital (Inpatient)	15%	30%
Observation Room/Outpatient Surgery (Hospital)	15%	30%
Outpatient Surgery (Ambulatory Center)	15%	30%
Home Health Care	15%	30%
Skilled Nursing Facility (100 days per benefit period)	\$20 per day 1-20/ 15% per day 21-100	30% per day 1-100
Dialysis	\$0	30%
Mental Health/Chemical Dependence Services	In-Network	Out-of-Network
Mental Health (Inpatient, 190-day lifetime limit)	15%	30%
Mental Health (Outpatient)	\$25	30%
Mental Health (Outpatient with Psychiatrist)	\$25	30%
Alcohol Substance Abuse (Inpatient)	15%	30%
Alcohol Substance Abuse (Outpatient)	\$25	30%

Laboratory and X-ray Services	In-Network	Out-of-Network
Laboratory Testing (Physician Office/Free Standing Lab)	15%	30%
Laboratory Testing (Outpatient Facility)	\$0	30%
X-rays	15%	30%
Advanced Radiology (MRI, MRA, PET, and CT)	15%	30%
Rehabilitation Services	In-Network	Out-of-Network
Physical, Occupational, and Speech Therapy	\$25	30%
Chiropractor Medicare Covered	\$20	30%
Cardiac Rehab	\$0	30%
Vision	In-Network	Out-of-Network
Medical Vision Exam	\$25	30%
Routine Vision Exam (Offered through Davis Vision)	\$0	\$50
Annual allowance (lenses and frames) Offered through Davis Vision	\$0 for Davis Vision Fashion Collection frames and standard lenses or \$150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses	\$150 benefit maximum
Hearing	In-Network	Out-of-Network
Diagnostic Hearing Exam	\$25	30%
Routine Hearing Exam (TruHearing)	\$25	30%
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a \$499 copay for the Advanced or a \$799 copay for the Premium hearing aid.	\$500 allowance for hearing aids every 3 years
Dental	In-Network	Out-of-Network
Routine Dental	Not Covered	Not Covered
Supplies, Equipment, and Devices	In-Network	Out-of-Network
Durable Medical Equipment	15%	30%
Prosthetics	15%	30%
Oxygen	15%	30%

Diabetic Supplies (Part B)	15%	30%
Fitness Program	In-Network	Out-of-Network
Highmark Fitness Program	Covered	
Part B Drugs	In-Network	Out-of-Network
Immunosuppressive Drugs	15%	30%
Oral Chemotherapy Drugs	15%	30%
Physician Administered Injectables	15%	30%
Nebulizer Inhalation	15%	30%
Part B drugs (other)	15%	30%
Value Added Rider	In-Network	Out-of-Network
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 8 per calendar year.	Not Covered	Not Covered
Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 10 visits per calendar year.	Not Covered	Not Covered
Meal Plan - 2 meals per day up to 14 days upon discharge from an Inpatient Hospital or SNF stay	Not Covered	Not Applicable
Over the Counter Drug Allowance	Not Covered	Not Applicable
Prescription Drugs - Part D		
Prescription Deductible	Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	\$2,000	
Formulary	Incentive	
Medicare Excluded Part D Prescription Drug Rider	Not Covered	
Retail Prescription Drugs		
Tier 1 (Preferred Generic)	\$15	
Tier 2 (Non-Preferred Generic)	\$15	
Tier 3 (Preferred Brand & Generic)	\$30	
Tier 4 (Non-Preferred)	\$60	
Tier 5 (Specialty)	\$60	
Mail Order Prescription Drugs		
Tier 1 (Preferred Generic)	\$25	
Tier 2 (Non-Preferred Generic)	\$25	
Tier 3 (Preferred Brand & Generic)	\$62.50	
Tier 4 (Non-Preferred)	\$137.50	
Tier 5 (Specialty)	\$60	
Retail and Mail Order Days Supply Limit	<ul style="list-style-type: none"> - Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply -Insulin - \$35 maximum copay for a one-month supply of covered insulin products 	
Catastrophic Phase	After reaching the True Out of Pocket (TrOOP) costs, there is \$0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

The Blue Cross(c), Blue Shield(c), Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express

Scripts® is a separate company. Other Pharmacies/Physicians/Providers are available in our network.

Out-of-network/non-contracted providers are under no obligation to treat Plan members except in emergency situations.

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.

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

For questions about this plan's benefits or costs, please call 1-866-456-7739 (TTY 711), Monday -Friday 8 am - 4:30 pm.

Please have this number ready when you call

25FB0178322