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	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$10	$15
Tier 2 (Non-Preferred Generic)	$10	$15
Tier 3 (Preferred Brand & Generic)	$25	$30
Tier 4 (Non-Preferred)	$55	$60
Tier 5 (Specialty)	$60	$60
Mail Order Prescription Drugs	**Express Scripts**	**All other Mail Order Pharmacies**
Tier 1 (Preferred Generic)	$25	$37.50
Tier 2 (Non-Preferred Generic)	$25	$37.50
Tier 3 (Preferred Brand & Generic)	$62.50	$75
Tier 4 (Non-Preferred)	$137.50	$150
Tier 5 (Specialty)	$60	$60
Retail and Mail Order Days Supply Limit	- 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.	

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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)
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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

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