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

Moravian University

0178335

2024 Benefit Summary

		Freedom Blue PPO	
		In Network	Out Of Network
	Monthly Plan Premium (per member)[1]	$255.00	
	Deductible	$0	
	In Network Member Out-of-Pocket Maximum (For Medicare-covered services, not including Part D drugs)	$3,400	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	$20 Copay	20% Coinsurance
	Specialist Office Visit	$25 Copay	20% Coinsurance
	Advanced Imaging (Examples: CT Scans, MRI)	0% Coinsurance	20% Coinsurance
	Standard Imaging (Examples: X-ray, Mammogram)	0% Coinsurance	20% Coinsurance
	Diagnostic Testing (Example: Blood Work)	0% Coinsurance	20% Coinsurance
	Outpatient Surgery	$50 Copay	20% Coinsurance
	Emergency Room Services (Worldwide Coverage)	$65 Copay	
	Urgently Needed Care	$40 Copay	
	Inpatient Hospital or Long-Term Acute Care Facility Stay	$100 Copay	20% Coinsurance

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

HEALTH	Skilled Nursing Facility Care (100 days per Medicare benefit period)	You pay: 0% per admission for days 1-100.	You pay: 20% per admission for days 1-100.
	Annual Routine Vision Exam (includes refraction)	$0 copay	$50 copay
	Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. $150 benefit maximum applies to non-standard frames and $150 benefit maximum for specialty contact lenses.	$150 benefit maximum
	Annual Routine Hearing Exam	$25 Copay	20% Coinsurance
	Hearing Aids (In-network covered every year)	$499 copay per aid per year for TruHearing Advanced $799 copay per aid per year for TruHearing Premium.	$500 allowance for hearing aids every 3 year.
	Annual Routine Dental Care	Not Covered	Not Covered
	Routine Podiatry Care Non-Medicare Covered (10 visits per calendar year)	Not covered	Not covered
	Routine Chiropractic Office Visits Non-Medicare Covered (8 visits per year)	Not covered	Not covered
	Home Health	0% Coinsurance	20% Coinsurance
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$25 Copay	20% Coinsurance
	Renal Dialysis	$0 Copay	20% Coinsurance

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

	Part B Drugs	**10% coinsurance, $300 quarterly member out-of-pocket maximum**	**20% Coinsurance**
	Ambulance (Emergent Services per one way trip)	**$50 Copay**	
	Ambulance (Non-Emergent per one way trip)	**$50 Copay**	**20% Coinsurance**
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)	**15% Coinsurance**	**20% Coinsurance**
	Oxygen/Oxygen Supplies	**15% Coinsurance**	**20% Coinsurance**
	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	**$100 Copay**	**20% Coinsurance**
	Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	**$25 Copay**	**20% Coinsurance**
	OnDuo	**Covered in Full**	

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

PART D DRUGS

You pay the following until your total yearly drug costs reaches $5,030 Total yearly drug costs are the total drug costs paid by both you and your Part D Plan.			
	Deductible	**$0**	
	Out of Pocket Maximum	**Not applicable**	
Initial Coverage	**Retail Cost Sharing (Preferred Pharmacy)**	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$10.00 Copay**
		Tier 2 (Generic)	**$10.00 Copay**
		Tier 3 (Preferred Brand)	**$25.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$55.00 Copay**
		Tier 5 (Specialty)	**$60.00 Copay**
	Retail Cost Sharing (Standard Pharmacy)	**Tier**	**Up to 31 Day Supply**
		Tier 1 (Preferred Generic)	**$15.00 Copay**
		Tier 2 (Generic)	**$15.00 Copay**
		Tier 3 (Preferred Brand)	**$30.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$60.00 Copay**
		Tier 5 (Specialty)	**$60.00 Copay**
	Mail Order Cost Sharing (Express Scripts)	**Tier**	**Up to 100 Day Supply - Tier 1 & 2 Up to 90 Day Supply- Tier 3 & 4**
		Tier 1 (Preferred Generic)	**$25.00 Copay**
		Tier 2 (Generic)	**$25.00 Copay**
		Tier 3 (Preferred Brand)	**$62.50 Copay**
		Tier 4 (Non-Preferred Drugs)	**$137.50 Copay**
		Tier 5 (Specialty)	**$60.00 Copay for a 31 day limit supply**
	Mail Order Cost Sharing (All other Mail Order Pharmacies)	**Tier**	**Up to 100 Day Supply - Tier 1 & 2 Up to 90 Day Supply- Tier 3 & 4**
		Tier 1 (Preferred Generic)	**$37.50 Copay**
		Tier 2 (Generic)	**$37.50 Copay**
		Tier 3 (Preferred Brand)	**$75.00 Copay**
		Tier 4 (Non-Preferred Drugs)	**$150.00 Copay**
		Tier 5 (Specialty)	**$60.00 Copay for a 31 day limit supply**
The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.01 until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.			

Coverage Gap	Retail Cost Sharing (Preferred Pharmacy)	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	$10.00 Copay
		Tier 2 (Generic)	$10.00 Copay
		Tier 3 (Preferred Brand)	20% of the cost
		Tier 4 (Non-Preferred Drugs)	20% of the cost
		Tier 5 (Specialty)	25% of the cost
	Retail Cost Sharing (Standard Pharmacy)	Tier	Up to 31 Day Supply
		Tier 1 (Preferred Generic)	$15.00 Copay
		Tier 2 (Generic)	$15.00 Copay
		Tier 3 (Preferred Brand)	25% of the cost
		Tier 4 (Non-Preferred Drugs)	25% of the cost
		Tier 5 (Specialty)	25% of the cost
	Mail Order Cost Sharing (Express Scripts)	Tier	Up to 100 Day Supply - Tier 1 & 2 Up to 90 Day Supply- Tier 3 & 4
		Tier 1 (Preferred Generic)	$25.00 Copay
		Tier 2 (Generic)	$25.00 Copay
		Tier 3 (Preferred Brand)	20% of the cost
		Tier 4 (Non-Preferred Drugs)	20% of the cost
		Tier 5 (Specialty)	25% of the cost for a 31 day limit supply
	Mail Order Cost Sharing (All other Mail Order Pharmacies)	Tier	Up to 100 Day Supply - Tier 1 & 2 Up to 90 Day Supply- Tier 3 & 4
		Tier 1 (Preferred Generic)	$37.50 Copay
		Tier 2 (Generic)	$37.50 Copay
		Tier 3 (Preferred Brand)	25% of the cost
		Tier 4 (Non-Preferred Drugs)	25% of the cost
		Tier 5 (Specialty)	25% Coinsurance for a 31 day limit supply
Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000.01, there is $0 member cost sharing for covered Part D drugs for any beneficiaries.			
Catastrophic Coverage	There is $0 member cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.		

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company

Your health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Shield provides post-sale administrative communications for these companies.

Highmark Blue Shield and Highmark Senior Health Company all of which 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 Monday-Friday from 8 a.m. to 4:30 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): 24FB0178335

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