



Contact Mary Schell (717)-302-3195 if you are interested in this plan!

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



2022 Benefit Summary

Moravian College

Freedom Blue PPO

178335

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

Skilled Nursing Facility Care (100 days per Medicare benefit period)	0% Coinsurance	20% Coinsurance
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 years.
Annual Routine Dental Care	Not Covered	Not Covered
Routine Podiatry Care (10 visits per calendar year)	Not covered	Not covered
Routine Chiropractic Office Visits (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

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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

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PART D DRUGS

You pay the following until your total yearly drug costs reaches \$4,130 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	Tier	Up to 90 Day Supply
		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
<p>The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130.01 until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>			
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	Tier	Up to 90 Day Supply
	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
Catastrophic Coverage Description: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$6,550.01, you pay the greater of: 5% of the cost or a \$3.70 copay for generics and a \$9.20 copay for all other drugs.		
Catastrophic Coverage	the greater of: 5% of the cost or a \$3.70 copay for generics and a \$9.20 copay for all other drugs.	

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 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): 21FB178335