HIGHMARK

Northeastern New York

Freedom Basic (PPO)

Summary of Benefits

January 1, 2024 to December 31, 2024

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington

This summary of benefits doesn't list every service, limitation, or special circumstance.
Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-329-2792** (TTY 711). We're available October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Freedom Basic (PPO) has a network of pharmacies. The out-of-network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

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	Freedom Basic (PPO)
Premium	$0.00
Part B Premium Reduction	$57.00
Deductible	$0
Max Out-Of-Pocket	$8,300 IN; $12,450 combined IN and OON
Inpatient Hospital Stay	Days 1 - 5: $400 copay per day per admit & Days 6 - 90: $0 copay per admit IN* with a $2,000 OOP Max per year; 50% coinsurance per admit OON
Outpatient Hospital Coverage	ASC[1]: $425 copay IN*; 50% coinsurance OON Facility: $475 copay IN*; 50% coinsurance OON
Doctor Office Visit	PCP: $10 copay IN; 50% coinsurance OON Specialist: $40 copay IN; 50% coinsurance OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN; 50% coinsurance OON
Emergency Room	$100 copay IN/OON
Urgently Needed Services	$55 copay IN/OON
Lab & Diagnostic Tests	Office Lab: $10 copay IN*; $10 copay OON; Outpatient Lab: $10 copay IN*; $10 copay OON Diagnostic Tests: $50 copay IN; 50% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: $50 copay IN*; 50% coinsurance OON Advanced Imaging: $200 copay IN*; 50% coinsurance OON
Hearing Services	Medicare Covered: $40 copay IN; 50% coinsurance OON; Routine: Not Covered; TruHearing Advanced: Not Covered; TruHearing Premium; Not Covered
Dental Services	Medicare Covered: $40 copay IN; 50% coinsurance OON. Office Visit: $20 copay per service IN; $20 copay per service OON (2 per year). X-Rays: $20 copay IN; $20 copay OON (1 per year). Comprehensive*: 50% coinsurance IN; 50% coinsurance OON; with a maximum $1,000 allowance (preventive and comprehensive combined) IN/OON (Per Year)
Vision Services	Medicare Covered: $40 copay IN; 50% coinsurance OON. Routine: $25 copay IN; 20% coinsurance OON (1 Per Year). $0 copay IN; 20% OON coinsurance for eyeglasses or contact lenses after cataract surgery.
Mental Health Services	Inpatient: Days 1 - 4: $395 copay per day per admit & Days 5 - 90: $0 copay per day per admit IN*; $1,580 OOP Max per year for IN; 50% coinsurance per day per admit OON; Outpatient: $40 copay IN; 50% coinsurance OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $203 copay/day (days 21-100) IN*; 50% coinsurance OON
Physical Therapy	$40 copay IN; 50% coinsurance OON
Ambulance (per one-way trip)	$305 copay IN*/OON
Transportation	Not covered
Part B Drugs[†]	20% coinsurance IN*; 50% coinsurance OON
Durable Medical Equipment	20% coinsurance IN*; 50% coinsurance OON $0 copay for compression stockings (IN only)
Fitness Benefit	SilverSneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Fundamental

*Indicates a service that requires prior authorization.

ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Freedom Basic (PPO)

DRUG

You pay the following until your total yearly drug costs reach $5,030 (excludes insulins).
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible	$350 on Tiers 3, 4 and 5			
Initial Coverage	**Preferred Retail Cost-Sharing**	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$14 Copay	$42 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$94 Copay	$282 Copay
		Tier 5 (Specialty Tier)	27% of the cost	Not Applicable
	Standard Retail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
		Tier 2 (Generic)	$19 Copay	$57 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay
		Tier 5 (Specialty Tier)	27% of the cost	Not Applicable
	Preferred Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
		Tier 2 (Generic)	$14 Copay	$35 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$42 Copay	$105 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$94 Copay	$235 Copay
		Tier 5 (Specialty Tier)	27% of the cost	Not Applicable
	Standard Mail Cost-Sharing	**Tier**	**31 Day Supply**	**100 Day (T1/2) 90 Day (T3/4)**
		Tier 1 (Preferred Generic)	$7 Copay	$17.50 Copay
		Tier 2 (Generic)	$19 Copay	$47.50 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$47 Copay	$117.50 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$100 Copay	$250 Copay
		Tier 5 (Specialty Tier)	27% of the cost	Not Applicable
Coverage Gap	The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.			
	Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)			
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark 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.

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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.

Out-of-network/non-contracted providers are under no obligation to treat Freedom Basic (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.

This information is not a complete description of benefits. Call 1-855-856-8348 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

SilverSneakers is a registered trademark of Tivity Health, Inc. Tivity Health, Inc., is a separate company that administers the SilverSneakers program.