HIGHMARK

Western Pennsylvania

Freedom Blue PPO

Summary of Benefits

January 1, 2026 to December 31, 2026

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:

Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, Westmoreland

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 **1-800-550-8722** (TTY 711). We're available 7 days a week, 8 a.m. to 8 p.m.

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 Blue 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 Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)
Premium	$79	$139
Part B Premium Reduction	$0	$0
Deductible	$0	$0
Max Out-Of-Pocket	$5,500 IN; $8,950 combined IN and OON	$5,000 IN; $8,950 combined IN and OON
Inpatient Hospital Stay	Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit IN*; Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay per admit OON	$350 copay per admit IN*; $350 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $175 copay IN*; $175 copay OON Facility: $200 copay IN*; $200 copay OON	ASC[1]: $125 copay IN*; $125 copay OON Facility: $175 copay IN*; $175 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $40 copay IN; $40 copay OON	PCP: $0 copay IN; $0 copay OON Specialist: $30 copay IN; $30 copay OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON	Covered in Full (Office visit copays may apply) IN/OON
Emergency Room	$130 copay IN/OON	$130 copay IN/OON
Urgently Needed Services	$50 copay IN/OON	$50 copay IN/OON
Lab & Diagnostic Tests	Freestanding Lab: $0 copay IN*; $20 copay OON Office/Outpatient: $20 copay IN*; $20 copay OON	Freestanding Lab: $0 copay IN*; $15 copay OON Office/Outpatient: $15 copay IN*; $15 copay OON
X-Rays/ Advanced Imaging	X-ray: $20 copay IN*; $20 copay OON Advanced Imaging: $200 copay IN*; $200 copay OON	X-ray: $20 copay IN*; $20 copay OON Advanced Imaging: $125 copay IN*; $125 copay OON
Hearing Services	Medicare Covered: $40 copay IN; $40 copay OON. Routine: $0 copay IN; $40 copay OON (1 Per Year). TruHearing Advanced: $599 copay (2 Aids Every Year IN/OON); TruHearing Premium: $899 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/Premium models	Medicare Covered: $30 copay IN; $30 copay OON. Routine: $0 copay IN; $30 copay OON (1 Per Year). TruHearing Advanced: $599 copay (2 Aids Every Year IN/OON); TruHearing Premium: $899 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/Premium models
Dental Services	Medicare Covered: $40 copay IN; $40 copay OON. Routine Office Visit/X-Ray: $15 copay (for any combination of oral exam, x-ray, and cleaning provided in a single visit). IN (2 per year for exams and cleanings; 1 per year for X-Ray); 30% coinsurance OON Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON	Medicare Covered: $30 copay IN; $30 copay OON. Routine Office Visit/X-Ray: $15 copay (for any combination of oral exam, x-ray, and cleaning provided in a single visit). IN (2 per year for exams and cleanings; 1 per year for X-Ray); 30% coinsurance OON Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON
Vision Services	Medicare Covered: $40 copay IN; $40 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $225 benefit max applies to non-standard frames or a $225 benefit max applies to specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).	Medicare Covered: $30 copay IN; $30 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $225 benefit max applies to non-standard frames or a $225 benefit max applies to specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay IN*; Days 1 - 5: $220 copay per day per admit & Days 6 - 90: $0 copay OON; Outpatient: $40 copay IN; $40 copay OON	Inpatient: $350 copay per admit IN*; $350 copay per admit OON; Outpatient: $30 copay IN; $30 copay OON
Skilled Nursing Facility	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON
Physical Therapy	$40 copay IN*; $40 copay OON	$30 copay IN*; $30 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $275 copay IN**; Non-Emergent: 30% coinsurance OON	Emergent/Non-Emergent: $300 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation (up-to 24 one-way trips)	$0 copay IN*; 30% coinsurance OON	$0 copay IN*; 30% coinsurance OON
Medicare Part B Drugs[†]	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON

	Freedom Blue PPO ValueRx (PPO)	Freedom Blue PPO Select (PPO)
OTC	Not Covered	Not Covered
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON	20% coinsurance IN*; 30% coinsurance OON
Formulary	Performance	Venture

	Freedom Blue PPO Classic (PPO)
Premium	$248
Part B Premium Reduction	$0
Deductible	$0
Max Out-Of-Pocket	$4,500 IN; $8,950 combined IN and OON
Inpatient Hospital Stay	$210 copay per admit IN*; $210 copay per admit OON
Outpatient Hospital Coverage	ASC[1]: $75 copay IN*; $75 copay OON Facility: $150 copay IN*; $150 copay OON
Doctor Office Visit	PCP: $0 copay IN; $0 copay OON Specialist: $25 copay IN; $25 copay OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON
Emergency Room	$130 copay IN/OON
Urgently Needed Services	$50 copay IN/OON
Lab & Diagnostic Tests	Freestanding Lab: $0 copay IN*; $10 copay OON Office/Outpatient: $10 copay IN*; $10 copay OON
X-Rays/ Advanced Imaging	X-ray: $15 copay IN*; $15 copay OON Advanced Imaging: $100 copay IN*; $100 copay OON
Hearing Services	Medicare Covered: $25 copay IN; $25 copay OON. Routine: $0 copay IN; $25 copay OON (1 Per Year). TruHearing Advanced: $599 copay (2 Aids Every Year IN/OON); TruHearing Premium: $899 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/ Premium models
Dental Services	Medicare Covered: $25 copay IN; $25 copay OON. Routine Office Visit/X-Ray: $15 copay (for any combination of oral exam, x-ray, and cleaning provided in a single visit). IN (2 per year for exams and cleanings; 1 per year for X-Ray); 30% coinsurance OON Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON
Vision Services	Medicare Covered: $25 copay IN; $25 copay OON. Routine: $0 copay IN; $50 copay OON (1 Per Year). Standard eyeglass lenses and frames or contact lenses are covered in full. IN/OON: A $225 benefit max applies to non-standard frames or a $225 benefit max applies to specialty contact lenses per year; $200 benefit max for post cataract eyewear (once per operated eye).
Mental Health Services	Inpatient: $210 copay per admit IN*; $210 copay per admit OON; Outpatient: $25 copay IN; $25 copay OON
Skilled Nursing Facility	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON
Physical Therapy	$25 copay IN*; $25 copay OON
Ambulance (per one-way trip)	Emergent/Non-Emergent: $255 copay IN**; Non-Emergent: 30% coinsurance OON
Transportation (up-to 24 one-way trips)	$0 copay IN*; 30% coinsurance OON
Medicare Part B Drugs†	20% coinsurance IN*; 30% coinsurance OON
OTC	Not Covered
Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON
Formulary	Venture

*Indicates a service that requires prior authorization.

**Indicates a service that requires prior authorization for non-emergent trips. 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 Blue PPO ValueRx (PPO)

DRUG

Deductible	$0			
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)	$13 Copay	$39 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	35% of the cost	35% of the cost
		Tier 5 (Specialty Tier)	33% 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)	$5 Copay	$15 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)	35% of the cost	35% of the cost
		Tier 5 (Specialty Tier)	33% 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)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$27 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	35% of the cost
		Tier 5 (Specialty Tier)	33% 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)	Not Applicable	$15 Copay
		Tier 2 (Generic)	Not Applicable	$57 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	35% of the cost
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, 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.

Freedom Blue PPO Select (PPO)

DRUG

Deductible	$0			
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)	$13 Copay	$39 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
		Tier 5 (Specialty Tier)	33% 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)	$5 Copay	$15 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)	33% 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)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$27 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
		Tier 5 (Specialty Tier)	33% 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)	Not Applicable	$15 Copay
		Tier 2 (Generic)	Not Applicable	$57 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, 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.

Freedom Blue PPO Classic (PPO)

DRUG

Deductible	$0			
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)	$13 Copay	$39 Copay
		Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
		Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
		Tier 4 (Insulin)	$35 Copay	$105 Copay
		Tier 4 (Non-Preferred Drug)	$95 Copay	$285 Copay
		Tier 5 (Specialty Tier)	33% 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)	$5 Copay	$15 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)	33% 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)	Not Applicable	$0 Copay
		Tier 2 (Generic)	Not Applicable	$27 Copay
		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$115 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$275 Copay
		Tier 5 (Specialty Tier)	33% 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)	Not Applicable	$15 Copay
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		Tier 3 (Preferred Insulin)	Not Applicable	$105 Copay
		Tier 3 (Preferred Brand)	Not Applicable	$141 Copay
		Tier 4 (Insulin)	Not Applicable	$105 Copay
		Tier 4 (Non-Preferred Drug)	Not Applicable	$300 Copay
		Tier 5 (Specialty Tier)	33% of the cost	Not Applicable
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $2,100, 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 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: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. The Blue Cross®, Blue Shield®, 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.

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 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.

This information is not a complete description of benefits. Call 1-866-746-7971 (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.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.