HIGHMARK

Western New York

Freedom Valor (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:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

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**

If you need printed copies, call us at **1-800-329-2792** (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 Valor (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 Valor (PPO)
Premium	$0
Part B Premium Reduction	$50
Deductible	$0
Max Out-Of-Pocket	$6,700 IN; $10,000 combined IN and OON
Inpatient Hospital Stay	Days 1 - 7: $290 copay per day per admit & Days 8 - 90: $0 copay per admit IN*; 50% coinsurance per admit OON
Outpatient Hospital Coverage	ASC[1]: $225 copay IN*; 50% coinsurance OON Facility: $325 copay IN*; 50% coinsurance OON
Doctor Office Visit	PCP: $0 copay IN; 50% coinsurance OON Specialist: $35 copay IN; 50% coinsurance OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN; 50% coinsurance OON
Emergency Room	$130 copay IN/OON
Urgently Needed Services	$40 copay IN/OON
Lab & Diagnostic Tests	Freestanding Lab: $0 copay IN*; 50% coinsurance OON Office/Outpatient: $10 copay IN*; 50% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: $45 copay IN*; 50% coinsurance OON Advanced Imaging: $150 copay IN*; 50% coinsurance OON
Hearing Services	Medicare Covered: $35 copay IN; 50% coinsurance OON. Routine: $0 copay IN; $45 copay OON (1 Per Year). TruHearing Advanced: $699 copay (2 Aids Every Year IN/OON); TruHearing Premium: $999 copay. (2 Aids Every Year IN/OON)
Dental Services	Medicare Covered: $35 copay IN; 50% coinsurance OON. Routine Office Visit: $0 copay IN; $0 copay OON (2 per year). Routine X-rays: $0 copay IN; $0 copay OON (1 per year). Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum $2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits.
Vision Services	Medicare Covered: $35 copay IN; 50% coinsurance OON. $0 diabetic retinal eye exam IN. Routine: $0 copay IN; 20% coinsurance OON (1 Per Year). $0 copay IN; 20% OON for eyeglasses or contact lenses after cataract surgery. $100 annual eyewear allowance IN/OON Combined.
Mental Health Services	Inpatient: Days 1 - 6: $260 copay per day per admit & Days 7 - 90: $0 copay per day per admit IN*; $1,560 OOP Max per year for IN; 50% coinsurance per day per admit OON; Outpatient: $5 copay IN; 50% coinsurance OON
Skilled Nursing Facility	$0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 50% coinsurance OON
Physical Therapy	$15 copay IN*; 50% coinsurance OON
Ambulance (per one-way trip)	$385 copay IN*/OON
Transportation	Not Covered
Medicare Part B Drugs[†]	20% coinsurance IN*; 50% coinsurance OON
OTC	$40 allowance once per quarter IN/OON
Durable Medical Equipment	0% Coinsurance for Compression stockings, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 20% Coinsurance for all other covered items IN*, 50% Coinsurance for Oxygen, Ventilators, Wheelchairs and Wheelchair Accessories, 40% Coinsurance for all other covered items OON
Formulary	Not Covered

*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.

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.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. 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.