HIGHMARK

## Central and Northeastern Pennsylvania

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## Freedom Blue PPO

# Summary of Benefits

**January 1, 2026 to December 31, 2026**

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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:

**Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York**

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 **1-800-550-8722** (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 Basic (PPO) | Freedom Blue PPO ValueRx (PPO) |
|---|---|---|
| Premium | $41 | $66 |
| Part B Premium Reduction | $18 | $0 |
| Deductible | $0 | $0 |
| Max Out-Of-Pocket | $5,900 IN; $8,950 combined IN and OON | $5,500 IN; $8,950 combined IN and OON |
| Inpatient Hospital Stay | $340 copay per admit IN*; $340 copay per admit OON | Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit IN*; Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay per admit OON |
| Outpatient Hospital Coverage | ASC[1]: $100 copay IN*; $100 copay OON<br>Facility: $200 copay IN*; $200 copay OON | ASC[1]: $200 copay IN*; $200 copay OON<br>Facility: $225 copay IN*; $225 copay OON |
| Doctor Office Visit | PCP: $0 copay IN; $0 copay OON<br>Specialist: $35 copay IN; $35 copay OON | PCP: $0 copay IN; $0 copay OON<br>Specialist: $40 copay IN; $40 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<br>Office/Outpatient: $20 copay IN*; $20 copay OON | Freestanding Lab: $0 copay IN*; $20 copay OON<br>Office/Outpatient: $20 copay IN*; $20 copay OON |
| X-Rays/ Advanced Imaging | X-ray: $25 copay IN*; $25 copay OON<br>Advanced Imaging: $150 copay IN*; $150 copay OON | X-ray: $25 copay IN*; $25 copay OON<br>Advanced Imaging: $175 copay IN*; $175 copay OON |
| Hearing Services | Medicare Covered: $35 copay IN; $35 copay OON. Routine: $0 copay IN; $35 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: $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 |
| Dental Services | Medicare Covered: $35 copay IN; $35 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<br>Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON | 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<br>Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON |
| Vision Services | Medicare Covered: $35 copay IN; $35 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: $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). |
| Mental Health Services | Inpatient: $340 copay per admit IN*; $340 copay per admit OON; Outpatient: $35 copay IN; $35 copay OON | Inpatient: Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay IN*; Days 1 - 5: $245 copay per day per admit & Days 6 - 90: $0 copay OON; Outpatient: $40 copay IN; $40 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 | $35 copay IN*; $35 copay OON | $40 copay IN*; $40 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: $270 copay IN**;<br>Non-Emergent: 30% coinsurance OON | Emergent/Non-Emergent: $270 copay IN**;<br>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 Basic (PPO) | Freedom Blue PPO ValueRx (PPO) |
|---|---|---|
| OTC | Not Covered | Not Covered |
| Durable Medical Equipment | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |
| Formulary | Not Covered | Performance |

| | Freedom Blue PPO Standard (PPO) | Freedom Blue PPO Deluxe (PPO) |
|---|---|---|
| Premium | $121 | $226 |
| Part B Premium Reduction | $18 | $19 |
| Deductible | $0 | $0 |
| Max Out-Of-Pocket | $5,000 IN; $8,950 combined IN and OON | $4,500 IN; $8,950 combined IN and OON |
| Inpatient Hospital Stay | $475 copay per admit IN*; $475 copay per admit OON | $235 copay per admit IN*; $235 copay per admit OON |
| Outpatient Hospital Coverage | ASC[1]: $150 copay IN*; $150 copay OON<br>Facility: $200 copay IN*; $200 copay OON | ASC[1]: $100 copay IN*; $100 copay OON<br>Facility: $175 copay IN*; $175 copay OON |
| Doctor Office Visit | PCP: $0 copay IN; $0 copay OON<br>Specialist: $35 copay IN; $35 copay OON | PCP: $0 copay IN; $0 copay OON<br>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*; $15 copay OON<br>Office/Outpatient: $15 copay IN*; $15 copay OON | Freestanding Lab: $0 copay IN*; $10 copay OON<br>Office/Outpatient: $10 copay IN*; $10 copay OON |
| X-Rays/ Advanced Imaging | X-ray: $20 copay IN*; $20 copay OON<br>Advanced Imaging: $125 copay IN*; $125 copay OON | X-ray: $10 copay IN*; $10 copay OON<br>Advanced Imaging: $75 copay IN*; $75 copay OON |
| Hearing Services | Medicare Covered: $35 copay IN; $35 copay OON.<br>Routine: $0 copay IN; $35 copay OON (1 Per Year).<br>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.<br>Routine: $0 copay IN; $30 copay OON (1 Per Year).<br>TruHearing Advanced: $399 copay (2 Aids Every Year IN/OON); TruHearing Premium: $699 copay (2 Aids Every Year IN/OON); $500 allowance IN/OON (per year) excludes Advanced/Premium models |
| Dental Services | Medicare Covered: $35 copay IN; $35 copay OON.<br>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<br>Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON | Medicare Covered: $30 copay IN; $30 copay OON.<br>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<br>Comprehensive: $0 copay: Adjunctive General Services (Palliative) IN; 30% coinsurance OON |
| Vision Services | Medicare Covered: $35 copay IN; $35 copay OON.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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.<br>Routine: $0 copay IN; $50 copay OON (1 Per Year).<br>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: $475 copay per admit IN*; $475 copay per admit OON; Outpatient: $35 copay IN; $35 copay OON | Inpatient: $235 copay per admit IN*; $235 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 | $35 copay IN*; $35 copay OON | $30 copay IN*; $30 copay OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: $260 copay IN**;<br>Non-Emergent: 30% coinsurance OON | Emergent/Non-Emergent: $275 copay IN**;<br>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 |
| OTC | Not Covered | Not Covered |
| Durable Medical Equipment | 20% coinsurance IN*; 30% coinsurance OON | 20% coinsurance IN*; 30% coinsurance OON |

| | Freedom Blue PPO Standard (PPO) | Freedom Blue PPO Deluxe (PPO) |
|---|---|---|
| Formulary | Venture | Venture |

| | Freedom Blue PPO Valor (PPO) |
|---|---|
| Premium | $0 |
| Part B Premium Reduction | $75 |
| Deductible | $0 |
| Max Out-Of-Pocket | $6,000 IN; $8,950 combined IN and OON |
| Inpatient Hospital Stay | $275 copay per admit IN*; $395 copay per admit OON |
| Outpatient Hospital Coverage | ASC[1]: $195 copay IN*; $350 copay OON<br>Facility: $245 copay IN*; $375 copay OON |
| Doctor Office Visit | PCP: $0 copay IN; 40% coinsurance OON<br>Specialist: $10 copay IN; 40% coinsurance OON |
| Preventive/Screening | Covered in Full (Office visit copays may apply) IN/OON |
| Emergency Room | $130 copay IN/OON |
| Urgently Needed Services | $40 copay IN/OON |
| Lab & Diagnostic Tests | Freestanding Lab: $0 copay IN*; 40% coinsurance OON<br>Office/Outpatient: $10 copay IN*; 40% coinsurance OON |
| X-Rays/ Advanced Imaging | X-ray: $20 copay IN*; 40% coinsurance OON<br>Advanced Imaging: $225 copay IN*; 40% coinsurance OON |
| Hearing Services | Medicare Covered: $10 copay IN; 40% coinsurance OON.<br>Routine: $0 copay IN; $0 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); $500 allowance IN/OON (per year) excludes Advanced/ Premium models |
| Dental Services | Medicare Covered: $10 copay IN; 40% coinsurance OON.<br>Routine Office Visit: $0 copay IN; 30% coinsurance OON (2 per year).<br>Routine X-rays: $0 copay IN; 30% coinsurance OON (1 per year).<br>Comprehensive: 0% coinsurance IN; 50% coinsurance OON;<br>with a maximum $3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits. |
| Vision Services | Medicare Covered: $10 copay IN; 40% coinsurance OON.<br>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 $200 benefit max applies to non-standard frames or a $200 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 - 3: $325 copay per day per admit & Days 4 - 90: $0 copay per day per admit IN*; Days 1 - 3: $475 copay per day per admit & Days 4 - 90: $0 copay per day per admit OON<br>Outpatient: $5 copay IN; 40% coinsurance OON |
| Skilled Nursing Facility | $0 copay/day (days 1 - 20), $218 copay/day (days 21 - 100) IN*; 30% coinsurance OON |
| Physical Therapy | $15 copay IN*; 40% coinsurance OON |
| Ambulance (per one-way trip) | Emergent/Non-Emergent: $275 copay IN**;<br>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 | $100 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*,<br>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.

**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) | 30% of the cost | 30% 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) | 30% of the cost | 30% 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 | 30% 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 | 30% 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 Standard (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 Deluxe (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.**

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.

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 Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. The Blue Shield® and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross 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.