

Southeastern Pennsylvania

Freedom Blue PPO

Summary of Benefits

January 1, 2025 to December 31, 2025

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:

Bucks, Chester, Philadelphia, Montgomery

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 8 a.m. to 8 p.m., 7 days a week.

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.

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.

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."

Part B Pemium		Freedom Blue PPO Valor
Deductible S0 Max Out-Of-Pocket S6,000 IN; \$8,950 combined IN and OON	Premium	\$0.00
Max Out-Of-Pocket Inpatient Hospital Sa00 copay per admit IN*, \$395 copay per admit OON Stay Outpatient Hospital Coverage Facility: \$250 copay IN*, \$325 copay OON Facility: \$250 copay IN*, \$375 copay OON Specialist: \$10 copay IN, \$10 copay OON Specialist: \$10 copay IN, \$10 copay OON Specialist: \$10 copay IN, \$10 copay OON Preventive/Screening Coverage Facility: \$250 copay IN, \$10 copay OON Specialist: \$10 copay IN, \$10 copay OON Services Lab & Diagnostic Tests X-Rays/ Advanced Imaging Advanced Imaging: \$225 copay IN*, \$35 copay OON Advanced Imaging: \$225 copay IN*, \$10 copay OON Routine: \$0 copay IN, \$10 copay OON, \$10 copay IN*, \$10 copay IN*, \$10 copay OON, \$10 copay IN*, \$10 copay OON, \$10 copay IN*, \$10 copay IN*, \$10 copay OON, \$10 copay IN*, \$10 copay IN*, \$10 copay OON, \$10 copay IN*, \$10 co	Part B Premium Reduction	\$60.00
Inpatient Hospital Stay Outpatient Hospital Coverage ASC': \$200 copay per admit IN*; \$395 copay per admit OON ASC': \$200 copay IN*; \$325 copay OON Poetro Office Visit PCP: \$0 copay IN; \$0 copay OON Specialist: \$10 copay IN; \$10 copay OON Preventive/Screening Emergency Room Urgently Needed Services Lab & Diagnostic Tests Array: \$20 copay IN*; \$35 copay OON; Outpatient: \$0 copay IN*; \$35 copay OON Bering Services Lab & Chapton Advanced Imaging: \$225 copay IN*; \$35 copay OON; Outpatient: \$0 copay IN*; \$35 copay OON Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$0 copay OON; (I Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year); \$500 allowance IN/OON (per year) Dental Services Medicare Covered: \$10 copay IN; \$10 copay OON, Routine: \$0 copay IN; \$10 copay OON, Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON, Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON, Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON, Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON, Routine: \$10 copay IN; \$10 copa	Deductible	\$0
Stay ASC': \$200 copay IN*, \$325 copay OON Coutpatient Hospital Coverage Facility: \$250 copay IN*, \$375 copay OON Speciality: \$250 copay IN, \$10 copay OON Speciality: \$10 copay IN; \$10 copay OON Speciality: \$10 copay IN*, \$10 copay OON Speciality: \$10 copay IN*, \$10 copay IN*, \$10 copay IN*, \$35 copay OON Speciality: \$10 copay IN*, \$35 copay OON, \$10 copay IN*, \$35 copay OON Speciality: \$10 copay IN*, \$35 copay OON, \$10 copay IN*, \$35 copay OON Southine: \$0 copay IN*, \$30 copay OON, \$10 copay IN*, \$35 copay IN*, \$35 copay OON, \$10 copay IN*, \$35 copay IN*, \$35 copay OON, \$10 copay IN*, \$35 copay OON, \$10 copay IN*, \$35	Max Out-Of-Pocket	\$6,000 IN; \$8,950 combined IN and OON
Coverage Facility: \$250 copay IN:* (\$375 copay OON PCP: 80 copay IN: \$10 copay OON Specialist: \$10 copay IN: \$10 copay OON Specialist: \$10 copay IN: \$10 cop	Inpatient Hospital Stay	\$300 copay per admit IN*; \$395 copay per admit OON
Specialist: \$10 copay IN; \$10 copay ON Preventive/Screening Covered in Full (Office visit copays may apply) IN/OON Services Lab & Diagnostic Tests X-Rays/ Advanced Imaging Hearing Services Hearing Services Hearing Services Lab & Diagnostic Copay IN; \$35 copay ON; Outpatient: \$0 copay IN*; \$35 copay OON Medicare Covered: \$10 copay IN; \$32 copay OON Medicare Covered: \$10 copay IN; \$10 copay OON Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay OON (per year) Dental Services Medicare Covered: \$10 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON (per year) Welciare Covered: \$10 copay IN; \$10 copay OON (per year) Welciare Covered: \$10 copay IN; \$10 copay OON (per year) Welciare Covered: \$10 copay IN; \$10 copay OON (per year) Welciare Covered: \$10 copay IN; \$10 copay OON (per year) Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay ON (per year) Services Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay ON (per year) Services Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay ON (per year) Services Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay ON (per year) Services Medicare Covered: \$10 copay IN; \$10 copay OON Solvatine: \$10 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay OON Solvatine: \$10 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay IN; \$10 copay IN; \$10	Outpatient Hospital Coverage	Facility: \$250 copay IN*; \$375 copay OON
Urgently Needed Services Services Cable & Diffice /Lab: \$0 copay IN/OON Office /Lab: \$0 copay IN*; \$35 copay OON; Outpatient: \$0 copay IN*; \$35 copay OON Tests X-Rays/ Advanced Imaging Advanced Imaging: \$225 copay IN*; \$325 copay OON Medicare Covered: \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$0 copay OON Routine: \$0 copay IN; \$10 copay OON Routine: \$10 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Office Visit: \$0 copay IN; \$10 copay OON Routine Soc copay IN; \$10 copay OON Routine: \$0 copay IN; \$10 copay	Doctor Office Visit	
Services	Preventive/Screening	Covered in Full (Office visit copays may apply) IN/OON
Services Lab & Diagnostic Tests X-Rays/ Advanced Imaging Medicare Covered: \$10 copay IN; \$35 copay OON Routine: \$0 copay IN; \$35 copay OON Routine: \$0 copay IN; \$35 copay OON Advanced Imaging: \$225 copay IN; \$325 copay OON Routine: \$0 copay IN; \$10 copay IN; \$10 copay OON Routine: \$0 copay IN; \$10 copay OON Routine X-rays: \$0 copay IN; \$10 copay OON Routine: \$0 copay IN; \$50 copay OON (1 per year). Comprehensive combined) IN/OON (Per Year). See the EOC for full benefits. Wedicare Covered: \$10 copay IN; \$10 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 \$200 benefit max applies to non-standard frames or a \$200 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye). Mental Health Services Mental Health Impatient: Days 1 - 3: \$325 copay per day per admit & Days 4 - 90: \$0 copay per day per admit & Days 4 - 90: \$0 copay per day per admit & Days 4 - 90: \$0 copay IN; \$35 copay OON Skilled Nursing Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per one-way trips) Medicare Part B Dirugs¹ 20% coinsurance OON Emergent: \$250 copay IN*; \$30% coinsurance OON Bedicare Part B Dirugs¹ 20% coinsurance IN*; 30% coinsurance OON Flex Card Not Covered	Emergency Room	\$125 copay IN/OON
X-Rays/ Advanced Imaging Advanced Imaging: \$225 copay IN*; \$35 copay OON Routine: \$0 copay IN; \$10 copay ON. Routine: \$0 copay IN; \$10 copay ON. Routine: \$0 copay IN; \$10 copay ON. Routine: \$0 copay IN; \$0 copay ON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year); \$500 allowance IN/OON (per year) Dental Services Medicare Covered: \$10 copay IN; \$10 copay ON. Routine Office Visit: \$0 copay IN; \$10 copay ON. Routine Office Visit: \$0 copay IN; \$10 copay ON. Routine Office Visit: \$0 copay IN; \$10 copay ON. Routine Office Visit: \$0 copay IN; \$10 copay ON. Routine Office Visit: \$0 copay IN; \$10 copay ON. Routine Covered: \$10 copay IN; \$10 copay ON. Routine: \$0 copay IN; \$50 copay ON (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 for post cataract eyewear (once per operated eye). Mental Health Services Mental Health Impatient: Days 1 - 3: \$325 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay IN; \$35 copay OON Skilled Nursing Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per one- way trip) \$16 copay IN*; \$30 coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B Drugs OTC \$100 allowance once per quarter IN/OON Not Covered	Urgently Needed Services	\$40 copay IN/OON
Imaging	Lab & Diagnostic Tests	Office /Lab: \$0 copay IN*; \$35 copay OON; Outpatient: \$0 copay IN*; \$35 copay OON
Routine: \$0 copay IN; \$0 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay (2 Aids Every Year); \$500 allowance IN/OON (per year) Medicare Covered: \$10 copay IN; \$10 copay OON. Routine Office Visit: \$0 copay IN; \$10 copay OON. Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per six months). Routine X-rays: \$0 copay IN; 30% coinsurance OON; with a maximum \$3,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). See the EOC for full benefits. Wision Services Medicare Covered: \$10 copay IN; \$10 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 \$200 benefit max for post cataract eyewear (once per operated eye). Mental Health Services Mental Health Services Mental Health Services Mental Health Services Stilled Nursing Facility Physical Therapy S15 copay IN*; \$35 copay OON S0 copay/day (days 1-20), \$214 copay/day (days 21-100) IN*; 30% coinsurance OON Emergent: Non-Emergent: \$250 copay IN**; Non-Emergent: \$250 c	X-Rays/ Advanced Imaging	
Routine Office Visit: \$0 copay IN; 30% coinsurance OON (1 per six months). Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 0% coinsurance IN; 50% coinsurance OON; 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; \$10 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 \$200 benefit max applies to non-standard frames or a \$200 benefit max for specialty contact lenses per year; \$200 benefit max for post cataract eyewear (once per operated eye). Inpatient: Days 1 - 3: \$325 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per admit IN*; Days 1 - 3: \$475 copay per day per admit OON; Outpatient: \$5 copay IN; \$35 copay OON Skilled Nursing Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per one-way trip) \$15 copay IN*; \$35 copay OON Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: \$250 copay IN**; Non-Emergent: 30% coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B Drugs¹ OTC \$100 allowance once per quarter IN/OON Not Covered	Hearing Services	Routine: \$0 copay IN; \$0 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay
Routine: \$0 copay IN; \$50 copay OON (I 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 for 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 admit IN*; Days 1 - 3: \$475 copay per day per admit & Days 4 - 90: \$0 copay per admit OON; Outpatient: \$5 copay IN; \$35 copay OON Skilled Nursing Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per one-way trip) Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: \$250 copay IN**; Non-Emergent: 30% coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B Drugs† OTC \$100 allowance once per quarter IN/OON Not Covered	Dental Services	Routine Office Visit: \$0 copay IN; 30% coinsurance OON (1 per six months). Routine X-rays: \$0 copay IN; 30% coinsurance OON (1 per year). Comprehensive: 0% coinsurance IN; 50% coinsurance OON; with a maximum \$3,000 allowance (preventive and
Services day per admit & Days 4 - 90: \$0 copay per day per admit OON; Outpatient: \$5 copay IN; \$35 copay OON Skilled Nursing Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per oneway trip) Transportation (up-to 24 one-way trips) Medicare Part B Drugs† OTC \$100 allowance once per quarter IN/OON Not Covered	Vision Services	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 for specialty contact lenses
Facility Physical Therapy \$15 copay IN*; \$35 copay OON Ambulance (per one- way trip) Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: 30% coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B Drugs† OTC \$100 allowance once per quarter IN/OON Flex Card Not Covered	Mental Health Services	
Ambulance (per one-way trip) Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: 30% coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B Drugs† OTC \$100 allowance once per quarter IN/OON Flex Card Emergent/Non-Emergent: \$250 copay IN**; Non-Emergent: \$	Skilled Nursing Facility	\$0 copay/day (days 1-20), \$214 copay/day (days 21-100) IN*; 30% coinsurance OON
way trip) Non-Emergent: 30% coinsurance OON Transportation (up-to 24 one-way trips) Medicare Part B 20% coinsurance IN*; 30% coinsurance OON Drugs† OTC \$100 allowance once per quarter IN/OON Flex Card Not Covered	Physical Therapy	
24 one-way trips) Medicare Part B Drugs [†] OTC \$100 allowance once per quarter IN/OON Flex Card Not Covered	Ambulance (per one- way trip)	
Drugs [†] OTC \$100 allowance once per quarter IN/OON Flex Card Not Covered	Transportation (up-to 24 one-way trips)	\$0 copay IN*; 30% coinsurance OON
Flex Card Not Covered	Medicare Part B Drugs [†]	20% coinsurance IN*; 30% coinsurance OON
	OTC	\$100 allowance once per quarter IN/OON
Durable Medical 20% coinsurance IN*; 30% coinsurance OON	Flex Card	Not Covered
	Durable Medical Equipment	20% coinsurance IN*; 30% coinsurance OON
Formulary Not Covered	Formulary	Not Covered

^{*}Indicates a service that requires prior authorization.

^{**}Indicates a service that requires prior authorization for non-emergent trips.



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 Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company, which are independent licensees of the Blue Cross Blue Shield Association. The Blue 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 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.

This information is not a complete description of benefits. Call 1-866-682-7972 (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.