

Western New York

Freedom Valor (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:

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
- 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 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."

Premium \$0.00 Part B Premium \$50.00 S50.00 S50.00 Reduction \$50.00 Reduction \$50.00 Reduction \$50.00 Reduction \$50.00 N; \$10,000 combined IN and OON Inpatient Hospital \$10 Days 1 - 7: \$290 copay per day per admit & Days 8 - 90: \$0 copay per admit IN* with a \$2,030 OOP Max per year; \$6% coinsurance per admit OON Outpatient Hospital \$10 Coverage \$10 Coverage \$10 Coverage \$10 Coverage \$10 Coverage \$10 Covered in Full (Office visit copays may apply) IN; \$5% coinsurance OON Specialists \$35 copay IN; \$5% coinsurance OON Preventive/Screening \$100 copay IN/OON \$100 Urgently Needed \$50 copay IN/OON \$20 Services \$10 Lab & Olagnostic Tests \$10 Diagnostic Tests: \$45 copay IN; \$5% coinsurance OON Diagnostic Tests: \$45 copay IN; \$5% coinsurance OON Hearing Services \$10 Hearing Services \$10 Medicare Covered: \$35 copay IN; \$5% coinsurance OON. Routine: \$45 copay IN; \$45 copay OON (1 Per Year). Trulflearing Advanced Imaging; \$150 copay IN; \$5% coinsurance OON. Routine: \$45 copay IN; \$45 copay IN; \$50% coinsurance OON. \$10 Dental Services \$10 Medicare Covered: \$35 copay IN; \$5% coinsurance OON. Routine: \$45 copay IN; \$45 copay OON (1 Per Year). Trulflearing Advanced: \$699 copay, "Irulflearing Premium: \$999 copay, (2 Aids Every Year IN/OON) \$10 Dental Services \$10 Medicare Covered: \$35 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON (1 per Year). \$20 Medicare Covered: \$35 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$5% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$50% coinsurance OON. (2 per year). \$20 Comprehensive: \$50 copay IN; \$50% coinsurance OON. (2 per year		
Part B Pemium Reduction South-Of-Pocket So Max Out-Of-Pocket So Out-Of-Pocket Days 1 - 7: \$290 copay per admit ON Days 1 - 7: \$290 copay per admit & Days 8 - 90: \$0 copay per admit IN* with a \$2,030 OOP Max per year; \$0% coinsurance Hospital Days 1 - 7: \$290 copay per admit & Days 8 - 90: \$0 copay per admit IN* with a \$2,030 OOP Max per year; \$0% coinsurance DON Dutpatient Hospital ASC: \$225 copay IN*; \$0% coinsurance OON PCP- \$0 copay IN*; \$0% coinsurance OON PCP- \$0 copay IN*; \$0% coinsurance OON Specialists \$35 copay IN*; \$0% coinsurance OON Specialists \$45 copay IN*; \$45 copay I		Freedom Valor (PPO)
Deductible 80 Max Out-OF-Pocket \$6,700 IN; \$10,000 combined IN and OON Inpatient Hospital Days 1 - 7: \$290 copay per day per admit & Days 8 - 90: \$0 copay per admit IN* with a \$2,030 OOP Max per year; 50% coinsurance per admit OON Outpatient Hospital Coverage Doctor Office Visit PCP: So copay IN; 50% coinsurance OON Specialist: \$35 copay IN*; 50% coinsurance OON Ingently Needed Services Lab & Diagnostic Tests Office Lab: \$0 copay IN*; 50% coinsurance OON; Outpatient Lab: \$0 copay IN*; 50% coinsurance OON Inaging Hearing Services Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Medicare Covered: \$35 copay IN*; 50% coinsurance OON Office Visit: \$0 copay: Trutificaring Premium: \$90 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$35 copay IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive acombined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive acombined) IN/OON (Per Year) So copay/day (days 1-20), \$203 copay/day (days 21-100) IN*; 50% coinsurance OON Mental Health Services Mental Health Services Presentive Services So copay IN, \$0% coinsurance OON So copay/day (days 1-20), \$203 copay/day (days 21-100) IN*; 50% coinsurance OON So copay/day (days 1-20), \$203 copay/day (days 21-100) IN*; 50% coinsurance OON Transportation Not covered So copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsu	Premium	
Max Out-Of-Pocket S6,700 IN; \$10,000 combined IN and OON	Part B Premium Reduction	\$50.00
Inpatient Hospital Stay Days 1 - 7: \$290 copay per day per admit & Days 8 - 90: \$0 copay per admit IN* with a \$2,030 OOP Max per year; 50% coinsurance Dox Coutpatient Hospital Coverage Doctor Office Visit PCP: \$0 copay IN*; 50% coinsurance OON Facility: \$325 copay IN*; 50% coinsurance OON Feventive/Screening Emergency Room S100 copay IN, 50% coinsurance OON Specialist: \$35 copay IN*; 50% coinsurance OON Preventive/Screening Emergency Room S100 copay IN/OON S55 copay IN*; 50% coinsurance OON Services Lab & Diagnostic Tests Diagnostic Tests: \$45 copay IN*; 50% coinsurance OON Gffice Lab: \$0 copay IN*; 50% coinsurance OON S-Rays/ Advanced Imaging Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Hearing Services Medicare Covered: \$35 copay IN, 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Medicare Covered: \$35 copay IN, 50% coinsurance OON Coffice Visit: \$0 copay IN*; 50% coinsurance OON Coffice Visit: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (2 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (1 per year). X-Rays: \$0 copay IN*; 50% coinsurance OON (Deductible	\$0
Outpatient Hospital Coverage Facility: \$225 copay IN*; 50% coinsurance OON Coverage Facility: \$325 copay IN*; 50% coinsurance OON Preventive/Screening PCP: \$0 copay IN; 50% coinsurance OON Preventive/Screening Emergency Room Urgently Needed Services Diagnostic Tests ARays/ Advanced Imaging Hearing Services Medicare Covered: \$35 copay IN*; 50% coinsurance OON Advanced Imaging: \$150 copay IN, 50% coinsurance OON Dental Services Medicare Covered: \$35 copay IN, 50% coinsurance OON Office Visit: \$0 copay IN, 50% coinsurance OON Diagnostic Tests: \$45 copay IN, 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Medicare Covered: \$35 copay IN; 50% coinsurance OON Advanced: \$699 copay; TruHearing Premium: \$999 copay; (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$35 copay IN; 50% coinsurance OON (2 per year). X-Rays: \$0 copay IN; \$0% coinsurance OON (2 per year). X-Rays: \$0 copay IN; \$0% coinsurance OON (2 per year). Comprehensive*: \$0% coinsurance IN; \$0% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). Welciaer Covered: \$35 copay IN; 50% coinsurance OON, With a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year). Welciaer Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPEr Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPER Year). Solve Covered: \$35 copay IN; 50% coinsurance OON, OPER	Max Out-Of-Pocket	\$6,700 IN; \$10,000 combined IN and OON
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Specialist: \$35 copay IN; 50% coinsurance OON	Outpatient Hospital Coverage	
Urgently Needed S55 copay IN/OON Services Lab & Diagnostic Tests Office Lab: \$0 copay IN*; 50% coinsurance OON; Outpatient Lab: \$0 copay IN*; 50% coinsurance OON Diagnostic Tests: \$45 copay IN*; 50% coinsurance OON Imaging X-Rays/ Advanced Imaging Hearing Services Medicare Covered: \$35 copay IN, 50% coinsurance OON Hearing Services Medicare Covered: \$35 copay IN, 50% coinsurance OON. Routine: \$45 copay IN, \$45 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$35 copay IN, 50% coinsurance OON. Routine: \$45 copay IN, \$45 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$35 copay IN, 50% coinsurance OON. (2 per year). X-Rays: \$0 copay IN, 9% coinsurance OON (1 per year). Comprehensive*: 50% coinsurance OON (2 per year). X-Rays: \$0 copay IN, 9% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN, 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN, 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN, 50% coinsurance OON Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). \$0 copay IN; 20% OON for eyeglasses or contact lenses after cataract surgery. \$100 annual eyewerar allowance IN/OON. Mental Health Inpatient: Days 1 - 6: \$260 copay per day per admit & Days 7 - 90: \$0 copay Per admit IN*; \$1,560 OOP Max per year for IN; 50% coinsurance per day per admit & Days 7 - 90: \$0 copay IN; 50% coinsurance OON Skilled Nursing Facility Physical Therapy \$15 copay IN; 50% coinsurance OON S200 copay IN*/OON ### Diagrams of the period of t	Doctor Office Visit	
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Services	Emergency Room	\$100 copay IN/OON
Tests Diagnostic Tests: \$45 copay IN; 50% coinsurance OON X-Rays/ Advanced Imaging: \$150 copay IN*; 50% coinsurance OON Hearing Services Medicare Covered: \$35 copay IN; 50% coinsurance OON. Routine: \$45 copay IN; \$45 copay OON (1 Per Year). TruHearing Advanced: \$699 copay; TruHearing Premium: \$999 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$35 copay IN; 50% coinsurance OON. Office Visit: \$0 copay IN; 50% coinsurance OON (2 per year). X-Rays: \$0 copay IN; 0% coinsurance OON (1 per year). Comprehensive*: 50% coinsurance OON (1 per year). Comprehensive*: 50% coinsurance OON (1 per year). Medicare Covered: \$35 copay IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and comprehensive combined) IN/OON (Per Year) Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON, Routine: \$25 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. Mental Health 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 Physical Therapy S15 copay IN; 50% coinsurance OON S200 copay IN*/OON Mental Drugs' 20% coinsurance IN*; 50% coinsurance OON Transportation Not covered Part B Drugs' 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical 20% coinsurance IN*; 50% coinsurance OON S0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Urgently Needed Services	\$55 copay IN/OON
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Office Visit: \$0 copay IN; 0% coinsurance OON (2 per year). X-Rays: \$0 copay IN; 0% coinsurance 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) Vision Services Medicare Covered: \$35 copay IN; 50% coinsurance OON. Routine: \$25 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. Mental Health 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 Physical Therapy \$15 copay IN; 50% coinsurance OON Ambulance (per oneway trip) Transportation Not covered Part B Drugs¹ 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical Equipment SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Hearing Services	Advanced: \$699 copay; TruHearing Premium: \$999 copay. (2 Aids Every Year IN/OON)
Routine: \$25 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. 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 Physical Therapy \$15 copay IN; 50% coinsurance OON Ambulance (per oneway trip) Transportation Not covered Part B Drugs¹ 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Dental Services	Office Visit: \$0 copay IN; 0% coinsurance OON (2 per year). X-Rays: \$0 copay IN; 0% coinsurance OON (1 per year). Comprehensive*: 50% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (preventive and
Services 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), \$203 copay/day (days 21-100) IN*; 50% coinsurance OON Physical Therapy \$15 copay IN; 50% coinsurance OON Ambulance (per oneway trip) \$200 copay IN*/OON Transportation Not covered Part B Drugs† 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Vision Services	Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). \$0 copay IN; 20% OON for eyeglasses or contact lenses
Facility Physical Therapy \$15 copay IN; 50% coinsurance OON Ambulance (per oneway trip) \$200 copay IN*/OON Transportation Not covered Part B Drugs† 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical 20% coinsurance IN*; 50% coinsurance OON Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Mental Health Services	
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Transportation Not covered Part B Drugs [†] 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical Equipment \$20% coinsurance IN*; 50% coinsurance OON Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Physical Therapy	\$15 copay IN; 50% coinsurance OON
Part B Drugs [†] 20% coinsurance IN*; 50% coinsurance OON OTC \$25 allowance once per quarter IN/OON Durable Medical 20% coinsurance IN*; 50% coinsurance OON Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Ambulance (per one- way trip)	\$200 copay IN*/OON
OTC \$25 allowance once per quarter IN/OON Durable Medical 20% coinsurance IN*; 50% coinsurance OON Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	Transportation	Not covered
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	Part B Drugs [†]	20% coinsurance IN*; 50% coinsurance OON
Equipment \$0 copay for compression stockings (IN only) Fitness Benefit SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON	OTC	
	Durable Medical Equipment	
Formulary Not Covered	Fitness Benefit	SilverSneakers covered in full IN; 50% coinsurance after satisfying a \$500 deductible OON
	Formulary	Not Covered

ASC¹=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.

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



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. The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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 Valor (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 1-844-537-7720 (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.

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