HIGHMARK® DELAWARE

Freedom Blue PPO sponsored by State of Delaware

Highmark BCBSD Inc. is a Medicare Advantage plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. depends on contract renewal.

Medical Benefits Chart

The *Medical Benefits Chart* on the following pages lists the services Freedom Blue PPO covers and what you pay out-of-pocket for each service. The services listed in the *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the *Medical Benefits Chart* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Freedom Blue PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the *Medical Benefits Chart*.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a $0 copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

Medical Benefits Chart

 **You will see this apple next to the preventive services in the benefits chart.**

✓ You will see this symbol next to a service that does not apply to the Out-of-Pocket Maximum.

	In-Network	Out-of-Network
Plan Deductible	None	
Plan Coinsurance	0%	See Benefit detail below for out-of-network coinsurance
Combined Out-of-Pocket Maximum	$1,000 Includes all Part A and Part B services and the Outpatient Professional services outside of the U.S. Excludes Private Duty Nursing.	

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.);	**In-Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit

Services that are covered for you	What you must pay when you get these services
• not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Services that are covered for you	What you must pay when you get these services
Ambulance services*	
• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. To meet this definition, the member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the member is bed-confined, and it is documented that the member's condition is such that other methods of transportation are contraindicated; or, if the member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. <u>Prior Authorization Requirements</u> All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member's non-emergent ambulance provider is responsible for obtaining prior authorization. Any non-emergency transportation services not prior authorized will not be covered.	**In-Network:** 0% coinsurance per one way trip for emergency and non-emergency ambulance services **Out-of-Network:** 0% coinsurance per one way trip for emergency ambulance services 0% coinsurance per one way trip for non-emergency ambulance services *Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Non-emergency ambulance services require a Physician Certification Statement (PCS).* Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.
Annual routine physical exam We cover one visit per calendar year. The exam services include:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual routine physical exam.

Services that are covered for you	What you must pay when you get these services
• Visual inspection of the body • Tapping specific areas of the body and listening to sounds • Checking vital signs and measuring height/weight	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bathroom safety devices* This benefit is part of your Durable Medicare Equipment benefit. (For a definition of "durable medical equipment," see Chapter 12 of the *Evidence of Coverage*.) Covered services are limited to: • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
quality, including a physician's interpretation of the results.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 (includes 3D mammogram) • One screening mammogram every calendar year for women aged 40 and older (includes 3D mammogram) • Clinical breast exams once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network:** $0 copay per service **Out-of-Network:** 0% coinsurance per service
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	What you must pay when you get these services
elevated risk of cardiovascular disease) once every 5 years (60 months).	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network:** $0 copay per Medicare-covered visit **Out-of-Network:** $0 copay per Medicare-covered visit
Colorectal cancer screening For people 45 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening CT Colonography for people ages 45-75 years old once every five years One of the following every calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If the screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and outpatient surgery cost sharing may apply.

Services that are covered for you	What you must pay when you get these services
• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	
Depression screening We cover one screening for depression per calendar year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**In-Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% coinsurance for diabetic supplies and therapeutic shoes

Services that are covered for you	What you must pay when you get these services
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests are covered 2 times per calendar year. • You must obtain diabetic testing supplies from Durable Medical Equipment (DME) suppliers. Diabetic testing supplies may be covered if purchased at an approved retail pharmacy. Call Member Service for details. • Certain DME providers in the Freedom Blue PPO network have agreed to provide blood glucose monitors free of charge. Call Member Service for details.	**Out-of-Network:** 0% coinsurance for diabetic supplies and therapeutic shoes
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 and Chapter 3, Section 7 of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your	**In-Network:** **Durable Medical Equipment:** 0% coinsurance for Medicare-covered items Your cost sharing for Medicare oxygen equipment coverage is 0%, every month. After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 0% for the oxygen contents.

Services that are covered for you	What you must pay when you get these services
area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at medicare.highmark.com. Reimbursement for oxygen services includes payment for equipment rental, oxygen contents, and all accessories and supplies as necessary. Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established. ***Prior authorization is required for certain items**	**Out-of-Network:** **Durable Medical Equipment:** 0% coinsurance for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 0% coinsurance for oxygen and oxygen related equipment *DME items must be purchased from a Medicare participating provider.*
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency care is covered worldwide.***	**In and Out-of-Network (including worldwide):** $0 copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment as these are not considered hospital admissions.

Services that are covered for you	What you must pay when you get these services
Foreign Travel*	
Inpatient Facility care received outside of the US which is not covered by Medicare but which meets Medicare criteria for inpatient care within the US (maximum of 150 days/year) Services must be approved by Highmark.	Inpatient and outpatient facility services 0% coinsurance
Outpatient Facility services not covered by Medicare because they were received outside of the US (but which would otherwise be defined by Medicare as covered services). Services must be approved by Highmark.	Professional services 80% coinsurance of the Highmark Delaware Plan Allowance (Member also pays any amount exceeding the Highmark Delaware Plan Allowance)
Professional Provider services not covered by Medicare because they were received outside of the US (but which would otherwise be defined by Medicare as covered services)	
Health and wellness education programs Highmark's health and wellness education program provides access to network gyms and fitness classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination through the Tivity, Inc. SilverSneakers® Fitness program. Eligible members receive a membership at network fitness facilities with access to all basic amenities plus SilverSneakers® fitness classes. SilverSneakers FLEX™ classes (which include tai chi, yoga and dance) are in neighborhood locations such as medical campuses, older-adult living communities and parks. SilverSneakers Steps®, which includes various kits for members to use at home or when they travel, is an available alternative for members who can't get to a network fitness location. For more information, to find SilverSneakers fitness locations and FLEX™ classes, or to get started with SilverSneakers Steps®, eligible	**In-Network:** There is no charge for the fitness program. **Out-of-Network (Fitness Facilities Outside of the SilverSneakers Network):** ✓ Because of the unique nature of health and wellness programs, the availability of comparable, equivalent programs may be limited. Program memberships or monthly dues that qualify for benefit coverage are subject to a 50% coinsurance after satisfying a $500 deductible which is not applied to the medical out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
members should visit silversneakers.com or call **1-888-423-4632** (TTY: 711 National Relay Service), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. *Routine hearing services are not covered.*	**In-Network:** $0 copay per Medicare-covered hearing exam **Out-of-Network:** $0 copay per Medicare-covered hearing exam
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every calendar year For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Prior authorization is required for certain Part B drugs.**	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit Medicare Part B drugs that are billed separately may be billed under the *Medicare Part B prescription drug* benefit (see below).

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not PPO. **In-Network:** $0 copay for a one time only hospice consultation with a primary care physician **Out-of-Network:** $0 copay for a one time only hospice consultation with a primary care physician

Services that are covered for you	What you must pay when you get these services
under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by Freedom Blue PPO PPO but are not covered by Medicare Part A or B: Freedom Blue PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services
• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • COVID-19 related services and stay requirements • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Private Duty Nursing • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	If a patient is admitted for an Inpatient Acute Hospital Care stay due to COVID-19, the cost share for this service will be waived both in and out-of-network. Inpatient rehabilitation is not included. **In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission Private Duty Nursing in an acute hospital setting is covered. You pay 20% coinsurance up to a 240 hour maximum within a 12 month period. You pay 100% after the maximum hours are met. The cost sharing for Privaty Duty Nursing is not applied to your Out of Pocket Maximum.

Services that are covered for you	What you must pay when you get these services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion up to a $10,000 allowance (some restrictions apply). Items not directly related to travel and lodging expenses are not payable. Please contact Member Service for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	

Services that are covered for you	What you must pay when you get these services
You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital* • Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	**In-Network:** $0 copay per primary care visit $0 copay per specialist visit $0 copay per radiation therapy visit 0% coinsurance for each advanced imaging service 0% coinsurance for lab services, x-rays and diagnostic procedures and tests 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment $0 copay per therapy type, per provider, per visit for rehabilitation services

Services that are covered for you	What you must pay when you get these services
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	**Out-of-Network:** $0 copay per primary care visit $0 copay per specialist visit 0% coinsurance per radiation therapy visit 0% coinsurance for diagnostic procedures, tests and lab services, advanced imaging services, outpatient x-ray, and diagnostic radiology services $0 copay per therapy type, per provider, per visit for rehabilitation services 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment
 **Meal benefit** Upon discharge from an inpatient hospital stay, you are eligible for up to 2 meals per day for 14 days to be delivered to your home. Benefit does not include discharge to or from a Skilled Nursing Facility. The benefit must be activated within 30 days of discharge and is limited to once per calendar year. Eligible members will be contacted to confirm enrollment to start the meals benefit.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for this benefit.
 **Medical nutrition therapy** This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
 **Medicare Diabetes Prevention Program (MDPP)** MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, toxoids, pathology drugs, laboratory drugs, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs

Services that are covered for you	What you must pay when you get these services
• Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com We also cover some vaccines under our Part B prescription drug benefit.	**Out-of-Network:** 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
Please note: *Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig and Nutri-System) are not eligible.*	
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-Network:** $0 copay per individual or group visit **Out-of-Network:** $0 copay per individual or group visit
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Advanced imaging services (such as CT scans and MRIs)	**In-Network:** 0% coinsurance for lab services, diagnostic procedures and tests, x-rays, and diagnostic radiology services including those performed in a freestanding lab, physicians office, or outpatient hospital facility 0% coinsurance for advanced imaging services/ diagnostic radiology tests $0 copay for therapeutic radiology services There is no coinsurance, copayment, or deductible for outpatient blood. **Out-of-Network:** 0% coinsurance for diagnostic procedures, tests and lab services, advanced imaging services,

Services that are covered for you	What you must pay when you get these services
• Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Other outpatient diagnostic tests	outpatient x-ray, outpatient blood, and diagnostic radiology services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D coverage.
Outpatient hospital services*	**In-Network:** $0 copay for emergency services

Services that are covered for you	What you must pay when you get these services
We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Advanced imaging services (such as CT scan and MRI) • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call	0% coinsurance per visit, per provider, per day for surgery performed in an ambulatory surgical center or outpatient hospital setting 0% coinsurance for partial hospitalization services $0 copay for each individual or group therapy visit for other mental health care services 0% coinsurance or lab services, diagnostic procedures and tests, x-rays and diagnostic radiology services 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) 0% coinsurance for durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** $0 copay for emergency services 0% coinsurance for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% coinsurance for diagnostic procedures, tests and lab services, x-ray and outpatient blood 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) $0 copay for each individual or group therapy visit for mental health services 0% coinsurance for Medicare-covered durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs

Services that are covered for you	What you must pay when you get these services
1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-Network:** $0 copay for each individual or group therapy visit **Out-of-Network:** $0 copay for each individual or group therapy visit
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network:** $0 copay per therapy, per provider, per visit **Out-of-Network:** $0 copay per therapy type, per provider, per visit
Outpatient substance abuse services* Individual and group therapy visits on an outpatient basis for substance abuse.	**Network:** $0 copay per individual or group visit **Out-of-Network:** $0 copay per individual or group visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you	**In-Network:** 0% coinsurance per service, per day, per provider **Out-of-Network:** 0% coinsurance per service, per day, per provider

Services that are covered for you	What you must pay when you get these services
stay in the hospital overnight, you might still be considered an "outpatient."	
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance abuse, occupational, physical and speech therapies ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person or telehealth visit will be the same for the type of service. **In-Network:** $0 copay per primary care in-person or telehealth visit $0 copay per specialist in-person or telehealth visit $0 copay per non-routine (Medicare-covered) dental in-person visit $0 copay per non-routine (Medicare-covered) hearing in-person visit 0% coinsurance per service, per day, per provider for each ambulatory surgical center and/or outpatient hospital facility visit **Out-of-Network:** $0 copay per primary care in-person or telehealth visit $0 copay per specialist in-person or telehealth visit $0 copay per non-routine (Medicare-covered) dental in-person visit

Services that are covered for you	What you must pay when you get these services
◦ Telehealth services are available using interactive audio and video telecommunications on your computer, tablet or mobile device. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	0% coinsurance for services at an ambulatory surgical center and/or outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)	**In-Network:** $0 copay per Medicare-covered visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copay per Medicare-covered visit
Prostate cancer screening exams For men age 50 and older, covered services include the following once every calendar year: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	**In-Network:** 0% coinsurance for Medicare-covered items **Out-of-Network:** 0% coinsurance for Medicare-covered items
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per calendar year for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	
 **Screening for lung cancer with low dose computed tomography (LDCT)** For qualified individuals, a LDCT is covered every calendar year. **Eligible members are:** people aged 50 – 80 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible)	Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the network cost share. Maximum coinsurance applies when enrollees choose to go to a non-network provider while in the Medicare Advantage National PPO service area. **In-Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** 0% coinsurance for renal dialysis

Services that are covered for you	What you must pay when you get these services
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 12 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") 100 days covered for each benefit period Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)	A benefit period starts the day you are admitted at a Medicare-certified hospital or skilled nursing facility. It ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **In-Network:** 0% coinsurance per admission for days 1-100 **Out-of-Network:** 0% coinsurance per admission for days 1-100

Services that are covered for you	What you must pay when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services
medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
Telehealth - Remote Access Provides access to in-network visits using interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. Coverage is limited to the following conditions: • medication reconciliation post-discharge • nutritional counseling • pharmacy clinic counseling (chronic disease and medication management) Any other conditions or services would not be covered. *Telehealth out-of-network services are not subject to the maximum out-of-pocket.*	**In-Network:** $0 copay per PCP visit $0 copay per specialist visit **Out-of-Network:** $0 copay per primary care visit $0 copay per specialist visit
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Urgently needed services are covered worldwide.**	**In and Out-of-Network (including worldwide):** $0 copay per visit

Services that are covered for you	What you must pay when you get these services
 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) A $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	**In-Network:** $0 copay per Medicare-covered eye exam **Out-of-Network:** $0 copay per Medicare-covered eye exam
 **"Welcome to Medicare" preventive visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Services that are covered for you	What you must pay when you get these services
and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	

ADDITIONAL PLAN INFORMATION

Upon enrollment into Freedom Blue PPO, you agree to the following:

Freedom Blue PPO will notify you in writing of your confirmed effective date of enrollment into Freedom Blue PPO. Typically, your effective date will be the 1st day of the month that the State of Delaware enrollment lists as your effective date for the Freedom Blue PPO plan.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware is a PPO plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. or Freedom Blue PPO depends on contract renewal.

You will need to keep your Medicare Parts A and Part B. You can be in only one Medicare Advantage plan at a time, and you understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan (other than the State of Delaware Part D Prescription Drug plan).

Once you are a member of Freedom Blue PPO, you have the right to appeal Plan decisions about payment or services if you disagree. This document along with the Freedom Blue PPO Evidence of Coverage (which is available to you) contains a full summary of the coverage rules associated with this plan. Other marketing materials present only highlights of the plan and not full coverage details.

If medically necessary, Freedom Blue PPO provides claims payment for all covered benefits, even if you get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in the Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without prior authorization (when required for select plan benefits), **neither Medicare nor Freedom Blue PPO will pay for the services**.

RELEASE OF INFORMATION:

Upon enrollment into this Medicare health plan, you acknowledge that Freedom Blue PPO will release your information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. You also acknowledge that Freedom Blue PPO will release your information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.