HIGHMARK®
SENIOR HEALTH COMPANY

Freedom Blue PPO sponsored by Pennsylvania's State System of Higher Education

Group #: 0198418

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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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- 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.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

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.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- 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 copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

Medical Benefits Chart - 0198418

 **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.

* You will see this symbol next to a service that requires prior authorization.

	In-Network	Out-of-Network
Plan Deductible	$257	
Plan Coinsurance	See Benefit detail below for in-network coinsurance	See Benefit detail below for out-of-network coinsurance
In-Network Out-of-Pocket Maximum	Not Applicable	
Combined Out-of-Pocket Maximum	$0	

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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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;	**In-Network:** $0 copay per Medicare-covered visit **Out-of-Network:** $0 copay per Medicare-covered visit

Services that are covered for you	What you must pay when you get these services
• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • 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	

Services that are covered for you	What you must pay when you get these services
required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, 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. If the covered ambulance services are not for an emergency situation, it should be 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 (requires a Physician Certification Statement (PCS)) 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 approved <u>non-emergency</u> ambulance services Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.

Services that are covered for you	What you must pay when you get these services
Annual routine physical exam We cover one visit per calendar year. The exam services include: • Visual inspection of the body • Tapping specific areas of the body and listening to sounds • Checking vital signs and measuring height/weight	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual routine physical exam. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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	**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
covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	*Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.*
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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
 **Cardiovascular disease testing** Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation • Routine chiropractic visits - provides maintenance manual manipulation of the spine. ✓ *Routine chiropractic visits do not apply to the maximum out-of-pocket.*	**In-Network:** $0 copay per Medicare-covered visit ✓ $0 copay routine per visit. **Out-of-Network:** $0 copay per Medicare-covered visit ✓ $0 copay per routine visit **In and Out-of-Network:** You have a total of 8 visits per year combined.
 **Colorectal cancer screening** The following screening tests are covered:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal

Services that are covered for you	What you must pay when you get these services
• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	cancer screening exam, excluding barium enemas, for which Medicare Part B cost sharing may apply. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you may have additional cost sharing that applies to the type of service received. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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 Abbott and Lifescan glucometers, diabetic test strips, lancets, and Abbott and Dexcom continuous glucose monitoring device are

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. ***Prior authorization is required for certain items**	available for dispense via a retail or mail order pharmacy. All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process). **Out-of-Network:** 0% coinsurance for diabetic supplies and therapeutic shoes *Physician or specialist cost sharing may apply for any non-preventive services also rendered at time of visit.*
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see Chapter 12 as well as 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.	**In-Network:** 0% coinsurance for Medicare-covered DME items Your cost sharing for Medicare-covered oxygen equipment coverage is 0% coinsurance, every month. After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 0% coinsurance for the oxygen contents.

Services that are covered for you	What you must pay when you get these services
We cover all medically necessary DME covered by Original Medicare. If our supplier in your 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:** 0% coinsurance for Medicare-covered DME items Your cost sharing is 0% coinsurance for Medicare-covered 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.	**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. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost sharing amount for the part of your stay after you are stabilized.

Services that are covered for you	What you must pay when you get these services
Emergency care is covered worldwide.	
Enhanced disease management **Onduo/VerilyMe Diabetes Management** is a virtual care program that helps individuals manage their diabetes. The Type 1 and Type 2 diabetes programs help guide individuals to eat healthier, be more active, and create other lifestyle changes. It includes diabetes testing supplies, app experiences, and support from personal coaches, clinicians and care specialists, including access to physicians through telemedicine when needed. To be eligible, the member must have diabetes and own a smartphone (to use the app). Other inclusion/ exclusion criteria may apply. **Highmark Mental Well-Being by Spring Health** offers a mental and behavioral health care program with digital tools/programs, coaching, and in-person and virtual clinical support to help members address a broad spectrum of behavioral health needs. **CHF and COPD management powered by Vida** offers a solution to treat and manage members with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). This program is only available using digital or smartphone technology. Members will receive help from dietitians, health coaches, in-app trackers, lessons on symptom monitoring, and regular mental health assessments.	There is no cost to eligible members.
Health and wellness education programs You have access to a nationwide network of gyms, local fitness studios, and community centers through FitOn Health. The number of credits you receive are set each month and do not rollover.	**In-Network and Out-of-Network:** You receive 32 credits per month; ✓ You pay 100% for visits exceeding your credit allowance.

Services that are covered for you	What you must pay when you get these services
Your FitOn account offers unlimited access to a digital library without using any of your 32 monthly credits. The digital library includes: • At-home fitness and wellness classes • Meditation classes • Nutrition and meal planning • Lifestyle advice • And much more To learn more about FitOn Health and to search for participating gyms and studios, visit www.fitonhealth.com/medicare. You can also find the credit cost per gym by visiting the FitOn Health website or by calling **1-855-946-4036** (TTY 711). Customer Service hours of operation are Monday through Friday, 8:00 a.m. to 9:00 p.m. If the cost for gym memberships exceeds your 32 monthly credit allowance, you will be responsible for purchasing additional credits to cover the cost difference at that facility. ✓*Any amount paid for health and wellness services that exceed your monthly credit allowance are not subject to the maximum out-of-pocket.*	
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. Covered services include: • 1 routine hearing exam per calendar year Hearing Aids: Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is	**In-Network:** $0 copay per Medicare-covered hearing exam ✓ $0 copay per annual routine hearing exam ✓ $499 per aid for TruHearing Advanced Aids ✓ $799 per aid for TruHearing Premium Aids **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Call **1-855-544-7171** (TTY users, dial 711) Monday through Friday, 9:00 a.m. to 9:00 p.m., Eastern Time to schedule an appointment. Hearing aid purchases <u>through a TruHearing provider</u> includes: • first year of hearing aid purchase provider visits • 60-day trial period • 3 year extended warranty • 80 batteries per aid for non-rechargeable models Benefit <u>does not</u> include or cover any of the following: • Additional provider visits • Ear molds • Hearing aid accessories • Extra batteries • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. *Plan deductible, if applicable, applies to out-of-network Medicare-covered hearing services.* ✓ *Routine hearing exams and hearing aid copays are not subject to plan deductible, if applicable, or the out-of-pocket maximum.*	$0 copay per Medicare-covered hearing exam ✓ $0 copay per annual routine hearing exam **In and Out-of-Network:** ✓ $500 allowance for any other hearing aids every 3 calendar years thru TruHearing or any other provider.

Services that are covered for you	What you must pay when you get these services
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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: • 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	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit Please reference *Durable medical equipment (DME) and related supplies* above for 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	**In-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
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 drugs.**	**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).
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	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 Freedom Blue 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
• 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 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 service <u>For services that are covered by Freedom Blue PPO but are not covered by Medicare Part A</u>	

Services that are covered for you	What you must pay when you get these services
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. For drugs that may be covered by the plan's Part D benefit:If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*) of the *Evidence of Coverage*. **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 vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. *A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.*

Services that are covered for you	What you must pay when you get these services
We also cover most other adult vaccines under our Part D prescription drug benefit.	
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: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • 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 use disorder services	**In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.

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 Freedom Blue 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 https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for x-rays and diagnostic procedures 0% coinsurance for lab services 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 **Out-of-Network:**

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 ***Prior authorization is required for certain procedures and DME** ✓ *Inpatient hospital services when not covered or authorized by our plan do not count toward your out-of-pocket maximum.*	$0 copay per primary care visit $0 copay per specialist visit 0% coinsurance for each advanced imaging service (MRI, MRA, CT and PET scan) 0% coinsurance for each outpatient x-ray and diagnostic procedures 0% coinsurance for each lab service $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 by case manager for details.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for coordinated meal requests.
 **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.	*A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.*
 **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 • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for all other Part B drugs **Out-of-Network:** 0% coinsurance for all other Part B drugs

Services that are covered for you	What you must pay when you get these services
• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • The Alzheimer's drug, Leqembi® , (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • 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 • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	

Services that are covered for you	What you must pay when you get these services
• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv,® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit® or Aranesp®)	

Services that are covered for you	What you must pay when you get these services
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) 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 and most adult vaccines under our Part D prescription drug benefit. Chapter 5 of the *Evidence of Coverage* explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 and the *Part D Prescription Drug Chart* in the back of the Annual Notice of Change.	
 **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. ***Please note:*** *Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig and Nutri-System) are not eligible.*	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit..*
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:	**In-Network:** $0 copay per individual or group visit

Services that are covered for you	What you must pay when you get these 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 disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**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 (MRI, MRA, CT and PET scan) • 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 *Either the freestanding or outpatient facility lab copay may apply in a physician's office setting. If your physician sends your lab or*	**In-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office There is no coinsurance, copayment, or deductible for outpatient blood. *Separate physician and specialist visit cost sharing may apply.* **Out-of-Network:** 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services

Services that are covered for you	What you must pay when you get these services
diagnostic test to another facility for analysis, you may be billed separately by the performing provider.	0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 0% coinsurance for lab services performed in a freestanding lab or physicians office
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 https://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. *Diagnostic testing will be subject to diagnostic cost sharing.* *Emergency Care cost sharing will apply if hospital observation is part of an emergency visit.*

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services*	**In-Network:**
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 (MRI, MRA, CT and PET scan) • 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 https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or	$0 copay for emergency services 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 for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services 0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility 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 per visit, per provider, per day for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% coinsurance for x-rays, diagnostic procedures and tests, and diagnostic radiology services 0% coinsurance for therapeutic radiology services

Services that are covered for you	What you must pay when you get these services
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.	0% coinsurance for advanced imaging services 0% coinsurance for lab services performed in an outpatient hospital facility $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
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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), 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 use disorder services Individual and group therapy visits on an outpatient basis for substance use disorders.	**In-Network:** $0 copay per individual or group visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
	$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 stay in the hospital overnight, you might still be considered an outpatient.	**In-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital **Out-of-Network:** 0% coinsurance per service, per day, per provider in an outpatient hospital
 **Over-the-Counter drug allowance** You can order certain over-the-counter drugs as specified by the plan. Orders can be made by phone, mail or online. Please contact the OTC Store at 1-800-560-9712 or visit Shophighmarkotc.com to access your benefits. The OTC fulfillment center is available Monday – Friday from 8 a.m. – 8 p.m., Eastern Time. ✓*This benefit does not apply to the maximum out-of-pocket.*	✓ $25 allowance per quarter Quarterly allowances cannot be carried over to another quarter. ✓ You are responsible for 100% of the cost of items not ordered through the OTC fulfillment center. No reimbursement is available for items purchased from any other provider.
Partial hospitalization services and Intensive outpatient 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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance

Services that are covered for you	What you must pay when you get these services
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	
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 visit $0 copay per specialist visit $0 copay per non-routine (Medicare-covered) hearing visit $0 copay per non-routine (Medicare-covered) dental 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 visit $0 copay per specialist visit $0 copay per non-routine (Medicare-covered) dental visit $0 copay per non-routine (Medicare-covered) hearing 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 per service, per day, per provider in an ambulatory surgical center and/ or outpatient hospital facility

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 ✓ $0 copay for each routine visit

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 • ✓ Routine podiatry visits - *do not apply to the out-of-pocket maximum*	**Out-of-Network:** $0 copay per Medicare-covered visit ✓ $0 copay per routine visit **In and Out-of-Network:** You have a total of 10 routine visits per year combined.
 **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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
Prosthetic and orthotic 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 testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic 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 copay per visit

Services that are covered for you	What you must pay when you get these services
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. 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.	**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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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 an 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 an 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	**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
lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
 **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 two 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. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*
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 in-network cost share. **Out-of-network coinsurance applies when enrollees choose to go to a non-network provider while <u>in</u> 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 copay for kidney disease education services

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**.	0% coinsurance for renal dialysis
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 **Out-of-Network:** 0% coinsurance per admission

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 or domestic partner is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Services that are covered for you	What you must pay when you get these services
<u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> 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.	**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
Transportation* Plan provides a benefit for up-to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits; appointments for dental, vision, hearing, and behavioral health services; and visits to pharmacies to pick up prescription drugs within a 50 mile limit. Destination must always be plan-approved. Mode of transportation could include van, medical transport, wheelchair van, or car at the discretion of the plan. If you pay out of pocket for these modes of transportation, reimbursement may be provided in special circumstances at the discretion of the plan; however, personal vehicle expenses will not be considered for reimbursement. Plan authorization and scheduling rules apply. Any routine transportation services not scheduled through the plan or prior-authorized will not be covered. To obtain prior authorization and schedule a pickup, please call us **at least 48 hours in**	**In-Network:** 0% coinsurance per one-way trip **Out-of-Network:** ✓ 50% coinsurance per one way-trip Transportation services that are arranged for you for continued acute care after discharge from an emergency room does not apply towards the trip limit. This is limited to a one way trip to the home and any round-trip to a physician's office related to the emergency condition.

Services that are covered for you	What you must pay when you get these services
advance. Contact Member Service at the phone number on the back of your ID card, 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday excluding holidays. TTY users should call 711 National Relay Service. ✓ *Transportation services do not apply to the maximum out-of-pocket.*	
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. **Urgently needed services are covered worldwide.**	**In and Out-of-Network (including worldwide):** $0 copay in-person or telehealth per visit *Not waived if admitted.* *Diagnostic testing may be subject to diagnostic cost sharing.*
 **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	**In-Network:** $0 copay per Medicare-covered eye exam ✓ $0 copay for routine eye exam and contact lens examination and fitting with a Davis Vision provider Davis Vision Collection eyeglass frames and standard plastic eyeglass lenses are covered in full.

Services that are covered for you	What you must pay when you get these services
• 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. **Routine vision care services include:** • One routine eye exam every calendar year, inclusive of dilation (when professionally indicated), per calendar year • One pair of standard eyeglass frames and standard plastic eyeglasses lenses per calendar year, or contact lenses per calendar year • This benefit cannot be combined with other special/promotional offers **Routine vision benefits are offered through Davis Vision.** Please contact Member Service for a list of participating providers.	**Out-of-Network:** $0 copay per Medicare-covered eye exam ✓ $50 copay for an annual routine comprehensive eye exam including dilation when warranted. **In and Out-of-Network:** ✓ A $150 allowance is available towards the purchase of any other frame/lenses or contacts at either a Davis Vision or out-of-network provider. This allowance is provided once per year and is valid for a single purchase/ transaction only.

Services that are covered for you	What you must pay when you get these services
✓ *Routine eye exams, fitting/evaluations, and eyewear do not apply to the maximum out-of-pocket.*	
 **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 and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), 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.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. *Physician, specialist or additional medically necessary diagnostic services cost sharing may apply for any non-preventive services rendered at the time of the visit.*

Part D Prescription Drugs Chart

The Deductible Stage

There is no deductible for Freedom Blue PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See below for information about your coverage in the Initial Coverage Stage.

The Initial Coverage Stage

A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Standard retail cost sharing (in-network) (up to a 31-day supply)	**Preferred retail cost sharing (in-network)** (up to a 31-day supply)	**Standard Mail-order cost sharing** (up to a 31-day supply)	**Preferred Mail-order cost sharing** (up to a 31-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Cost Sharing Tier 1 (Preferred Generic)	$5 copay	$0 copay	31-day mail order not available	31-day mail order not available	$5 copay	$5 copay

	Standard retail cost sharing (in-network) (up to a 31-day supply)	Preferred retail cost sharing (in-network) (up to a 31-day supply)	Standard Mail-order cost sharing (up to a 31-day supply)	Preferred Mail-order cost sharing (up to a 31-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
Cost Sharing Tier 2 (Generic)	$5 copay	$0 copay	31-day mail order not available	31-day mail order not available	$5 copay	$5 copay
Cost Sharing Tier 3 (Preferred Brand)	$15 copay	$10 copay	31-day mail order not available	31-day mail order not available	$15 copay	$15 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$15 copay	$10 copay	31-day mail order not available	31-day mail order not available	$15 copay	$15 copay
Cost Sharing Tier 5 (Specialty)	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay

A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an *extended supply*) when you fill your prescription. A long-term supply is up to a 100-day supply for Tiers 1 and 2. It is a 90-day supply for Tiers 3 and 4.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard retail cost sharing (in-network) (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)	**Preferred retail cost sharing (in-network)** (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)	**Standard Mail-order cost sharing** (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)	**Preferred Mail-order cost sharing** (Tiers 1/2 - up to a 100-day supply, Tiers 3/4 - up to a 90 day supply)
Cost Sharing Tier 1 (Preferred Generic)	$15 copay	$0 copay	$10 copay	$0 copay
Cost Sharing Tier 2 (Generic)	$15 copay	$0 copay	$10 copay	$0 copay
Cost Sharing Tier 3 (Preferred Brand)	$45 copay	$30 copay	$30 copay	$20 copay
Cost Sharing Tier 4 (Non-Preferred Drug)	$45 copay	$30 copay	$30 copay	$20 copay
Cost Sharing Tier 5 (Specialty)	*A long-term supply is not available for drugs in Specialty Tier 5*	*A long-term supply is not available for drugs in Specialty Tier 5*	*A long-term supply is not available for drugs in Specialty Tier 5*	*A long-term supply is not available for drugs in Specialty Tier 5*

The Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, you pay nothing for your covered Part D drugs.

Your cost for excluded drugs not covered by Part D but covered under our enhanced drug benefit will be the same as the Initial Coverage Stage.

Important Information about Certain Medicare Excluded Prescription Drugs

The following is a list of Medicare Part D excluded drugs covered under your plan. The cost sharing for these drugs is Generic-Tier 2 and Brand-Tier 4 listed in your plan documents.

Drug Name	Requirements/Limits
Caverject Vial (ea) 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg and 20 mcg	QL (0.2 EA per 1 day), *, +
Cialis Tablet 2.5 mg	QL (2 EA per 1 day), *, +
Cialis Tablet 5 mg	QL (1 EA per 1 day), *, +
Cialis Tablet 10 mg and 20 mg	QL (0.2 EA per 1 day), *, +
Drisdol 1.25 MG (50,000 Unit)	*, +
Edex Kit 10 mcg, 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Ergocal Ciferol 1.25 mg	*, +
Folic Acid Tablet 1 mg	*, +
IFE-BIMIX 30/1 150-5 MG/5 ML	QL (0.2 EA per 1 day), *, +
IFE-PG20 100 MCG/5 ML VIAL	QL (0.2 EA per 1 day), *, +
Levitra Tablet 2.5 mg, 5 mg, 10 mg and 20 mg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 125 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 250 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 500 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 1000 mcg	QL (0.2 EA per 1 day), *, +
PAPAVRN 30 MG-PHENTO 1 MG/ML	QL (0.2 EA per 1 day), *, +
PPVRN 12MG-PHNT 1MG-ALPR 10MCG	QL (0.2 EA per 1 day), *, +
PPVRN 30MG-PHNT 1MG-ALPR 20MCG	QL (0.2 EA per 1 day), *, +
Promethazine HCL/Codeine Syrup 6.25-10/5	*, +
Promethazine DM Syrup 6.25-15/5	*, +
Sildenafil 25 MG, 50MG and 100 MG TABLET	QL (0.2 EA per 1 day), *, +
Staxyn Tablet, Disintegrating 10 mg	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg, 100 mg and 200 mg	*, +
Tadalafil 2.5 MG TABLET	QL (2 EA per 1 day), *, +
Tadalafil 5 MG TABLET	QL (1 EA per 1 day), *, +
Tadalafil 10 MG and 20 MG TABLET	QL (0.2 EA per 1 day), *, +
TRI-MIX 150 MG-5 MG-50 MCG VL	QL (0.2 EA per 1 day), *, +
Viagra Tablet 25 mg, 50 mg and 100 mg	QL (0.2 EA per 1 day), *, +
Vitamin D2 1.25MG(50,000 UNIT)	*, +
Vitamin D2 50 MCG (2,000 UNIT)	*, +

+ - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you quality for catastrophic coverage). In addition, if you are

receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

You can find information on what the symbols and abbreviations on this table mean by going to page 10 of the formulary.