Plan: Freedom Nation

Monthly premium effective January 1, 2025	2024 Benefits		2025 Benefits	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0		$0	
Coinsurance (see specific benefits for cost sharing)	0%	50%	0%	50%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$6,750	Not Applicable	$6,750	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$11,300		$10,100	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$0	50%	$0	50%
Office Visits - Specialist	$30	50%	$30	50%
Radiation Therapy	20%	50%	20%	50%
Emergency Room (waived if admitted within 1 day)	$125		$125	
Urgent Care	$55		$55	
Ambulance	$325		$325	
More than 20 Preventive Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	$375 per day for days 1-6, $2,250 OOP Max per year IN	50%	$375 per day for days 1-6, $2,250 OOP Max per year IN	50%
Observation Room/Outpatient Surgery (Hospital)	$375	50%	$375	50%
Outpatient Surgery (Ambulatory Center)	$275	50%	$275	50%
Home Health Care	$0	50%	$0	50%
Skilled Nursing Facility (100 days per benefit period)	$0 per day for days 1-20; $214.00 per day for days 21-100, No yearly benefit period maximum IN	50%	$0 per day for days 1-20; $214.00 per day for days 21-100, No yearly benefit period maximum IN	50%
Dialysis	$0 Copay IN	50%	$0 Copay IN	50%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	$370 per day for days 1-5, $1,850 OOP Max per year IN	50%	$370 per day for days 1-5, $1,850 OOP Max per year IN	50%
Mental Health (Outpatient)	$40	50%	$40	50%
Mental Health (Outpatient with Psychiatrist)	$40	50%	$40	50%
Alcohol Substance Abuse (Inpatient)	$370 per day for days 1-5, $1,850 OOP Max per year IN	50%	$370 per day for days 1-5, $1,850 OOP Max per year IN	50%
Alcohol Substance Abuse (Outpatient)	$40	50%	$40	50%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$5 Lab Copay IN; $50 Diagnostic Tests IN	Lab $5 Copay OON; Diagnostic Test 50% Coinsurance OON	$5 Lab Copay IN; $50 Diagnostic Tests IN	Lab $5 Copay OON; Diagnostic Test 50% Coinsurance OON
Laboratory Testing (Outpatient Facility)	$5 Lab Copay IN; $50 Diagnostic Tests IN	Lab $5 Copay OON; Diagnostic Test 50% Coinsurance OON	$5 Lab Copay IN; $50 Diagnostic Tests IN	Lab $5 Copay OON; Diagnostic Test 50% Coinsurance OON
X-rays	$50	50%	$50	50%
Advanced Radiology (MRI, MRA, PET, and CT)	$200	50%	$200	50%
Rehabilitation Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$25	50%	$25	50%
Chiropractor Medicare Covered	$15	50%	$15	50%
Acupuncture & Massage Therapy Annual Allowance	$250		Not Covered	
Cardiac Rehab	$10	50%	$10	50%
Vision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Vision Exam	$30 (except $0 for diabetic retinal eye exam)	50%	$10	$15

Routine Vision Exam (Offered through Davis Vision)	$25 Copay IN (1 Every Year)	20%	$0	$0
Annual allowance (lenses and frames) Offered through Davis Vision	$100		$300	
Hearing	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$30	50%	$30	50%
Routine Hearing Exam (TruHearing)	$45	Not Applicable	$45	Not Applicable
Hearing Aid Benefit (TruHearing)	2 Hearing Aids Every year; TruHearing Advanced - $699 copay; TruHearing Premium - $999 copay	Not Applicable	2 Hearing Aids Every year; TruHearing Advanced - $699 copay; TruHearing Premium - $999 copay	Not Applicable
Dental	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Dental Allowance	$2,000		$2,000	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	$0 compression stockings; 20% all other items	50%	$0 compression stockings; 20% all other items	50%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	50%	$0 diabetic shoes/inserts; 20% all other items	50%
Oxygen	20%	50%	20%	50%
Diabetic Supplies (Part B)	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN	$35	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN	$35
Fitness Program	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Silversneakers		National Fitness Network	
Part B Drugs	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Immunosuppressive Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%
Oral Chemotherapy Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%
Physician Administered Injectables	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%
Nebulizer Inhalation	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%
Part B drugs (other)	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN	50%
Value Added Rider	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 12 per calendar year.	$15 Copay IN (6 per plan year)	50%	$15 Copay IN (6 per plan year)	50%
Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 3 visits per calendar year.	$30 Copay IN (3 visits)	50%	$30 Copay IN (3 visits)	50%
Meal Plan - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Prescription Drugs - Part D				
Prescription Deductible	Tier 1 -Tier 3: $0, Tier 4 - Tier 5: $200		Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	Not Applicable		$2,000	
Formulary	Fundamental		Fundamental	
Retail Prescription Drugs (for up to a 31 day supply)	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$0	$5	$0	$5
Tier 2 (Non-Preferred Generic)	$5	$17	$5	$17
Tier 3 (Preferred Brand & Generic)	$42	$47	25%	25%
Tier 4 (Non-Preferred)	$94	$100	49%	49%
Tier 5 (Specialty)	29%	29%	33%	33%

Mail Order Prescription Drugs	Express Scripts	All other Mail Order Pharmacies	Express Scripts	All other Mail Order Pharmacies
Tier 1 (Preferred Generic)	$0	$12.50	$0	$12.50
Tier 2 (Non-Preferred Generic)	$0	$42.50	$0	$42.50
Tier 3 (Preferred Brand & Generic)	$105	$117.50	25%	25%
Tier 4 (Non-Preferred)	$235	$250	49%	49%
Tier 5 (Specialty)	29%	29%	33%	33%
Retail and Mail Order Days Supply Limit	Retail or Mail Order -Tier 1 & 2 Up to a 100 day supply Retail or Mail Order - Tier 3 & 4 Up to a 90 day supply Specialty Drugs are limited to a 31-day supply Insulin - $35 maximum copay for a one-month supply of covered insulin products		Retail or Mail Order -Tier 1 & 2 Up to a 100 day supply Retail or Mail Order - Tier 3 & 4 Up to a 90 day supply Specialty Drugs are limited to a 31-day supply Insulin - $35 maximum copay for a one-month supply of covered insulin products	
Catastrophic Phase	After reaching Out of Pocket costs of $8,000, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.		After reaching the True Out of Pocket (TrOOP) costs, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	

Total Premium Per Member, Per Month	$24	$30

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