

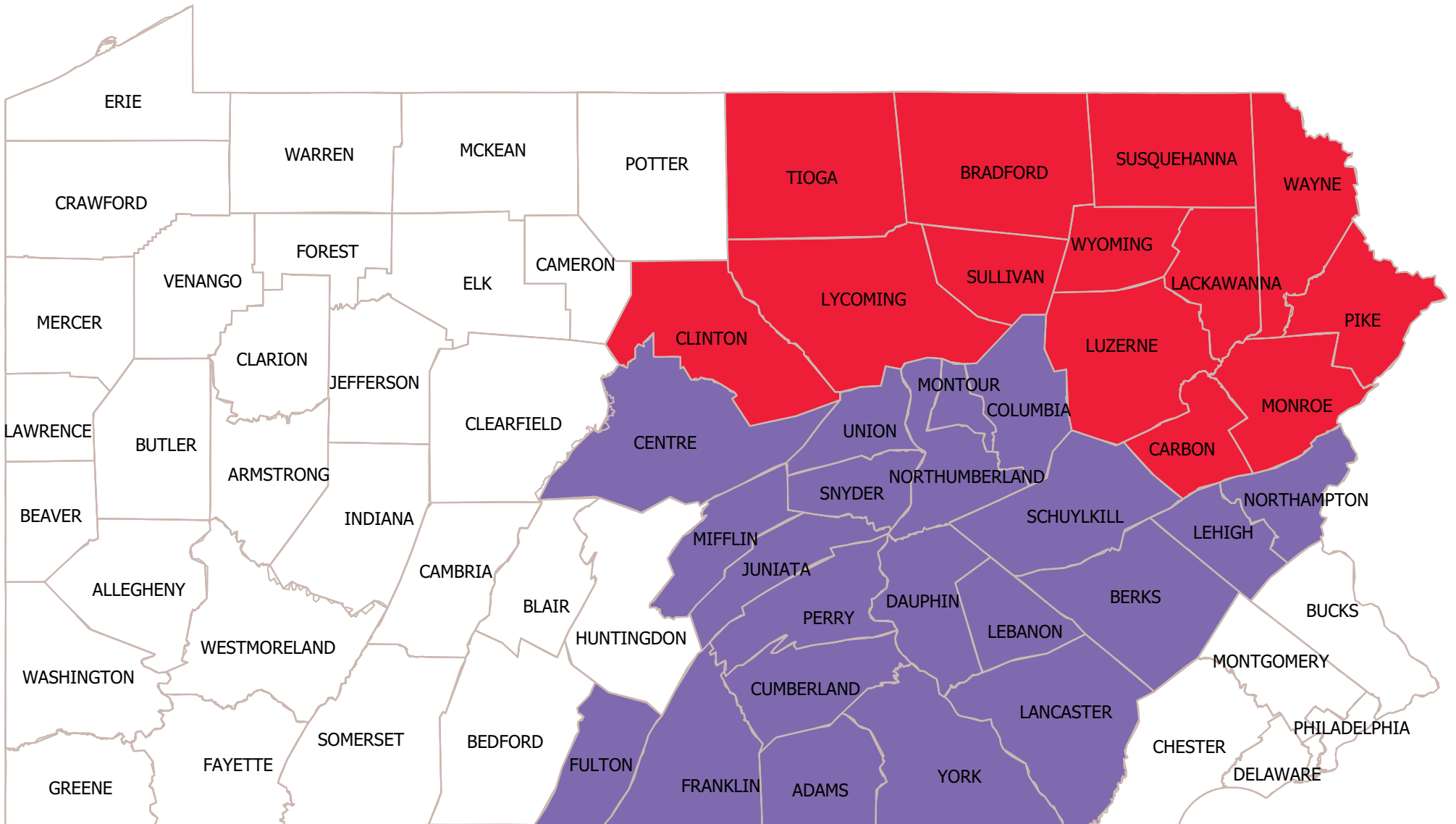
FreedomBlue PPO (Central & Northeastern Pennsylvania)

	Value	HD	BasicRx	Standard	Deluxe
Premium	\$40	\$0 - \$1,100 Deductible	\$34	\$102	\$138
PCP Office Visit	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit	\$10 per visit
Specialist Office Visit	\$25 per visit	\$15 per visit	\$35 per visit	\$25 per visit	\$25 per visit
Diagnostic Tests	\$15 Copay	Covered in full after deductible	\$15 Copay	Covered In Full	Covered In Full
XRays/Advanced Imaging	\$15 X-Ray/\$50 Adv. Imaging	Covered in full after deductible	\$15 X-Ray/\$50 Adv. Imaging	\$10 X-Ray/\$50 Adv. Imaging	Covered In Full
Preventive/Screening <i>(Mammograms, PAP, Colorectal, Prostate, Immunizations - Flu/Pneu.)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>	Covered In Full <i>(Office visit copay may apply)</i>
Outpatient Rehab	\$25 Copay	Covered in full after deductible	\$35 Copay	\$25 Copay	\$25 Copay
Outpatient Surgical	\$50 Copay	Covered in full after deductible	\$100 Copay	\$50 Copay	Covered In Full
Ambulance <i>(per one way trip)</i>	\$75 Copay	Covered in full after deductible	\$75 Copay	\$75 Copay	\$50 Copay
Emergency Room	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay	\$50 Copay
Inpatient Hospital Stay	\$250/admit, \$500 OOP max	Covered in full after deductible	\$250/admit, \$750 OOP max	\$100/admit, \$200 OOP max	100% coverage
Skilled Nursing Facility <i>(days 1-100 per benefit period)</i>	\$35/day (days 16-55)/admit, \$1,000 annual OOP max	Covered in full after deductible	\$50/day (days 16-55)/admit, \$2,000 OOP max	\$25/day (days 16-55)/admit, \$1,000 OOP max	\$25/day (days 16-55)/admit, \$1,000 OOP max
Home Health	Covered In Full <i>(when part of approved plan of care)</i>	Covered In full after deductible <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>	Covered In Full <i>(when part of approved plan of care)</i>
Durable Medical Equipment	15% coinsurance \$750 OOP Max	100% after \$500 benefit deductible	15% coinsurance \$500 OOP Max	15% coinsurance \$500 OOP Max	15% coinsurance \$500 OOP Max
Routine Vision <i>(every 2 years)</i>	Davis Network: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. Out-of-Network: \$100 benefit maximum for eyewear.	Davis Network: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. Out-of-Network: \$100 benefit maximum for eyewear.	Davis Network: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. Out-of-Network: \$100 benefit maximum for eyewear.	Davis Network: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. Out-of-Network: \$100 benefit maximum for eyewear.	Davis Network: Standard eyeglass lenses and frames or contact lenses are covered in full. A \$100 benefit maximum applies to non-standard frames and a \$100 benefit maximum for specialty contact lenses. Out-of-Network: \$100 benefit maximum for eyewear.
Routine Hearing	\$500 every 3 years	\$500 every 3 years	\$500 every 3 years	\$500 every 3 years	\$1,000 every 3 years
Routine Dental	Not Covered	30% coinsurance;40% coinsurance for dentures	Not Covered	Not Covered	30% coinsurance;40% coinsurance for dentures
Routine Chiro/Podiatry	Not Covered	Not Covered	Not Covered	Not Covered	Rout. Podiatry: 10 per cal. yr, Rout. Chiro: 8 per cal. yr.
Out-of-Network	\$500 Ded., 30% OON Coin.	30% OON Coin. after Plan Ded.	\$500 Ded., 30% OON Coin.	\$500 Ded., 20% OON Coin.	\$500 Ded., 20% OON Coin.
OOP Max in and out-of-network	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max	\$3,400 OOP Max
Part D Drugs <i>(Up to 34 Days)</i>					
Initial Coverage <i>(Up to \$2,830 in total Rx Costs)</i>	Not Covered	\$7 Generic, \$42 Preferred Brand, \$90 Non-Pref Brand, 33% Spec	\$7 Generic, \$42 Preferred Brand, \$90 Non-Pref Brand, 33% Spec	\$7 Generic, \$42 Preferred Brand, \$80 Non-Pref Brand, 33% Spec	\$6 Gen, \$40 Pref. Brand, \$80 Non-Pref Brand, 33% Spec
Coverage Gap <i>(From \$2,830 in total Rx Costs to \$4,550 Member OOP)</i>	Not Covered	Not Covered	Not Covered	Not Covered	Generics Covered (\$5)
Catastrophic Coverage <i>(From \$4,550 Member OOP)</i>	Not Covered	Greater of: 5% or \$2.50 Gen/Multi Source or \$6.30 for all others	Greater of: 5% or \$2.50 Gen/Multi Source or \$6.30 for all others	Greater of: 5% or \$2.50 Gen/Multi Source or \$6.30 for all others	Greater of: 5% or \$2.50 Gen/Multi Source or \$6.30 for all others
Mail Order Drugs <i>(Initial Coverage Period) - Up to 90 Days)</i>	Not Covered	\$17.50 Generic, \$105 Preferred Brand, \$225 Non-Pref Brand, 33% Specialty	\$17.50 Generic, \$105 Preferred Brand, \$225 Non-Pref Brand, 33% Specialty	\$17.50 Generic, \$105 Preferred Brand, \$200 Non-Pref Brand, 33% Specialty	\$15 Gen, \$100 Pref Brand, \$200 Non-Pref Brand, 33% Specialty

FreedomBlue PPO (Central and Northeastern PA) Regions

Central - Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York Counties

NEPA - Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming Counties



FreedomBlue PPO East Central/NEPA Service Area

