

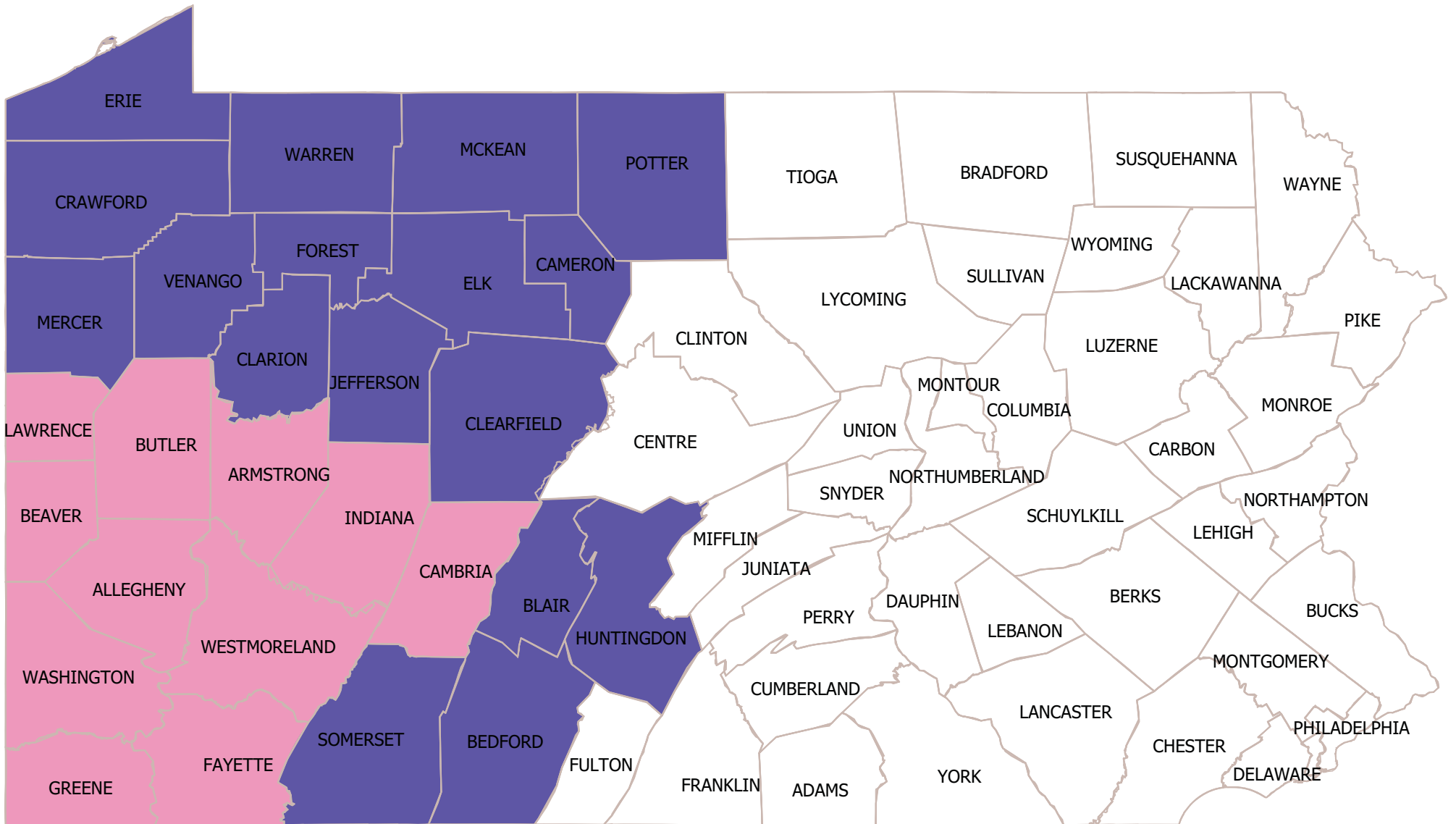
FreedomBlue PPO (Western Pennsylvania)

	HD	Select	Classic	Platinum
Premium (By Region)	\$0 - All Regions	SW- \$55	SW- \$167	SW- \$218
	SW - \$1,200 Deductible	WC - \$51	WC - \$133	WC- \$179
	WC - \$1,000 Deductible			
PCP Office Visit	\$15 per visit	\$20 per visit	\$10 per visit	\$0 per visit
Specialist Office Visit	\$15 per visit	\$30 per visit	\$25 per visit	\$10 per visit
Diagnostic Tests	Covered in full after deductible	\$20 Copay	Covered In Full	Covered In Full
XRays/Advanced Imaging	Covered in full after deductible	\$20 X-Ray/\$50 Advanced Imaging	\$10 X-Ray/\$50 Advanced Imaging	Covered In Full
Preventive/Screening <i>(Mammograms, PAP Test, Colorectal, Prostate, Immunizations - Flu/Pneumonia)</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	Covered in full after deductible	\$30 Copay	\$25 Copay	Covered In Full
Outpatient Surgical	Covered in full after deductible	\$100 Copay	\$50 Copay	Covered In Full
Ambulance (per one way trip)	Covered in full after deductible	\$100 Copay	\$100 Copay	\$25 Copay
Emergency Room	\$50 Copay	\$50 Copay	\$50 Copay	Covered In Full
Inpatient Hospital Stay	Covered in full after deductible	\$200/admit, \$600 OOP max	\$100/admit, \$300 OOP max	Covered In Full
Skilled Nursing Facility <i>(days 1-100 per benefit period)</i>	Covered in full after deductible	\$60/day (days 16-55)/admit, \$2,400 OOP max	\$50/day (days 16-55)/admit, \$2,000 annual OOP max	\$25/day (days 16-55)/admit, \$1,000 annual OOP max
Home Health	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	100% after \$500 benefit deductible	15% coinsurance, \$500 OOP Max	15% coinsurance, \$500 OOP Max	15% coinsurance, \$500 OOP Max
Routine Vision (every 2 years)	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 for hearing aid(s) every 3 years	\$500 for hearing aid(s) every 3 years	\$500 for hearing aid(s) every 3 years	\$1,000 for hearing aid(s) every 3 years
Routine Dental	30% coinsurance;40% coinsurance for dentures	Not Covered	30% coinsurance;40% coinsurance for dentures	30% coinsurance;40% coinsurance for dentures
Routine Chiro/Podiatry	Not Covered	Not Covered	Routine Podiatry: 10 per calendar year, Routine Chiro: 8 per calendar year.	Routine Podiatry: 10 per calendar year, Routine Chiro: 8 per calendar year.
Out-of-Network	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
Part D Drugs <i>(Up to 34 Days)</i>				
Initial Coverage (Up to \$2,830 in total Rx Costs)	\$7 Generic, \$42 Preferred Brand, \$90 Non-Pref Brand, 33% Specialty	\$7 Generic, \$45 Preferred Brand, \$90 Non-Pref Brand, 33% Specialty	\$7 Generic, \$42 Preferred Brand, \$80 Non-Pref Brand, 33% Specialty	\$6 Generic, \$40 Preferred Brand, \$80 Non-Pref Brand, 33% Specialty
Coverage Gap (From \$2,830 in total Rx Costs to \$4,550 Member OOP)	Not Covered	Not Covered	Not Covered	Generics Covered (\$6)
Catastrophic Coverage (From \$4,550 Member OOP)	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 (Initial Coverage Period) - Up to 90 Days)	\$17.50 Generic, \$105 Preferred Brand, \$225 Non-Pref Brand, 33% Specialty	\$17.50 Generic, \$112.50 Preferred Brand, \$225 Non-Pref Brand, 33% Specialty	\$17.50 Generic, \$105 Preferred Brand, \$200 Non-Pref Brand, 33% Specialty	\$15 Generics, \$100 Preferred Brand, \$200 Non-Pref Brand, 33% Specialty

FreedomBlue PPO (Western PA) Regions

SW (Southwest) - Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland Counties

WC - Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango and Warren Counties



FreedomBlue PPO Western PA Service Area

