## FreedomBlue PPO (Western Pennsylvania)

| | HD | Select | Classic | Platinum |
|---|---|---|---|---|
| **Premium (By Region)** | $0 - All Regions<br>SW - $1,450 Deductible<br>WC - $1,250 Deductible | SW- $73<br>WC - $68 | SW- $192<br>WC - $157 | SW- $260<br>WC- $226 |
| **PCP Office Visit** | $15 per visit | $20 per visit | $10 per visit | $0 per visit |
| **Specialist Office Visit** | $25 per visit | $30 per visit | $25 per visit | $10 per visit |
| **Lab & 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** *(Mammograms, PAP Test, Colorectal, Prostate, Immunizations - Flu/Pneumonia)* | Covered In Full *(Office visit copay may apply)* | Covered In Full *(Office visit copay may apply)* | Covered In Full *(Office visit copay may apply)* | Covered In Full *(Office visit copay may apply)* |
| **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)* | $75 Copay | $100 Copay | $100 Copay | $25 Copay |
| **Transportation** *(Wheelchair Van per one way trip)* | $40 Copay | $40 Copay | $40 Copay | $10 Copay |
| **Emergency Room** | $50 Copay | $50 Copay | $50 Copay | Covered In Full |
| **Inpatient Hospital Stay** | Covered in full after deductible | $200/admit | $100/admit | Covered In Full |
| **Skilled Nursing Facility** *(days 1-100 per benefit period)* | Covered in full after deductible | $60/day (days 16-75)/admit | $50/day (days 16-75)/admit | $25/day (days 16-75)/admit |
| **Home Health** | Covered In full after deductible *(when part of approved plan of care)* | Covered In Full *(when part of approved plan of care)* | Covered In Full *(when part of approved plan of care)* | Covered In Full *(when part of approved plan of care)* |
| **Durable Medical Equipment** | Covered in full after deductible | 15% coinsurance | 15% coinsurance | 15% coinsurance |
| **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 | Routine Podiatry: 10 per calendar year, Routine Chiro: 8 per calendar year. | 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. |
| **Network Maximum OOP** | $3,400 INN OOP Max | $3,400 INN OOP Max | $3,400 INN OOP Max | $3,400 INN OOP Max |
| **Catastrophic OOP** | $5,100 OOP Max | $5,100 OOP Max | $5,100 OOP Max | $5,100 OOP Max |
| **Part D Drugs** *(Up to 34 Days)* | | | | |
| **Initial Coverage** *(Up to $2,840 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 $2,840 in total Rx Costs to $4,550 Member OOP)* | Generics (93% coins)<br>Brand Discount (50%)[1] | Generics (93% coins)<br>Brand Discount (50%)[1] | Generics (50% coins)<br>Brand Discount (50%)[1] | Generics Covered ($6)<br>Brand Discount (50%)[1] |
| **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 |

*[1] The Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand name drugs from manufacturers that have agreed to pay the discount.*

**FreedomBlue PPO (Western PA) Regions**

**SW** - 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

***Internal and Agent Use Only - Not For Distribution***

ERIE
WARREN
MCKEAN
POTTER
TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
WYOMING
FOREST
CAMERON
SULLIVAN
LACKAWANNA
VENANGO
ELK
LYCOMING
MERCER
PIKE
CLINTON
LUZERNE
CLARION
JEFFERSON
MONTOUR
COLUMBIA
MONROE
CLEARFIELD
LAWRENCE
UNION
BUTLER
CENTRE
CARBON
ARMSTRONG
NORTHUMBERLAND
SNYDER
NORTHAMPTON
BEAVER
INDIANA
SCHUYLKILL
MIFFLIN
LEHIGH
JUNIATA
CAMBRIA
ALLEGHENY
BERKS
BLAIR
DAUPHIN
BUCKS
PERRY
HUNTINGDON
LEBANON
WESTMORELAND
MONTGOMERY
WASHINGTON
CUMBERLAND
LANCASTER
PHILADELPHIA
SOMERSET
BEDFORD
CHESTER
FAYETTE
FULTON
DELAWARE
FRANKLIN
YORK
GREENE
ADAMS

# FreedomBlue PPO Western PA Service Area