

Questions? Call 1-866-456-7739  
(TTY User, call 1-800-862-0709)

**Reference Code: 10FB9880**

(Please have this number ready when you call.)

*Highmark Blue Shield is an Independent Licensee  
of the Blue Cross and Blue Shield Association*

### 2010 FreedomBlue PPO Benefit Summary

If you receive services in the Plan Service Area from network providers, you will receive the highest level of benefits. No referrals required. The benefit levels are listed below.

<b>Benefits</b>		
	<b>Network</b>	<b>Out-of-Network</b>
<b>Deductible</b>	\$0	\$250
<b>Maximum Annual Out-of-Pocket</b>	\$3400	\$3400
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Preventive Care</b>		
	<b>Network</b>	<b>Out-of-Network</b>
<b>Annual Physical Exam</b>	Covered at 100% Office visit cost sharing may apply	Covered at 100% Office visit cost sharing may apply
<b>Preventative Screening PAP/Pelvic Exams</b>	Covered at 100%	Covered at 100%
<b>Preventive Screening Mammograms</b>	Covered at 100%	Covered at 100%
<b>Colorectal Preventive Screening Exams</b>	Covered at 100%	Covered at 100%
<b>Prostate Preventive Screening Exams</b>	Covered at 100%	Covered at 100%
<b>Bone Mass Measurement Preventive Screening Exams</b>	Covered at 100%	Covered at 100%
<b>Immunizations</b> (Not covered for purposes of travel)	Covered at 100%	Covered at 100%
<b>Vision Care (Davis Vision Network)</b>		
	<b>Network</b>	<b>Out-of-Network</b>
<b>Annual Routine Vision Exam</b> (includes refraction)	\$15 copay	Covered at 80%; you pay 20%
<b>Routine Vision Eye Wear</b> Benefit limited to one pair of eyeglass frames AND either one pair of contact lenses OR one pair eyeglass lenses every two years	100% coverage for standard eyeglass frames, lenses, or contact lenses \$100 benefit maximum for specialty frames \$100 benefit maximum for specialty contact lenses	\$100 benefit maximum for eye wear

## Hearing Services

	Network	Out-of-Network
<b>Annual Routine Hearing Exam</b>	\$15 copay	Covered at 80%; you pay 20%
<b>Hearing Aids</b>	\$500 benefit maximum for one or more hearing aids every three years	

## Outpatient Services

	Network	Out-of-Network
<b>Primary Care Home/Office Visits</b>	\$15 copay	Covered at 80%; you pay 20%
<b>Specialist Home/Office Visits</b>	\$15 copay	Covered at 80%; you pay 20%
<b>Outpatient Surgery and Invasive Procedures</b> (per visit/per day/per provider)	Covered at 100%	Covered at 80%; you pay 20%
<b>Diagnostic Procedures/Tests</b>	Covered at 100%	Covered at 80%; you pay 20%
<b>Lab Services</b>	Covered at 100%	Covered at 80%; you pay 20%
<b>X-Rays and Diagnostic Radiological Services</b>	Covered at 100%	Covered at 80%; you pay 20%

## Supplies and Services

	Network	Out-of-Network
<b>Ambulance</b> (Emergent Services per one way trip)	\$25 Copay	Covered at 80%; you pay 20%
<b>Ambulance</b> (Non-emergent Services per one way trip)	\$25 Copay	Covered at 80%; you pay 20%
<b>Durable Medical Equipment/Prosthetics/Orthotics</b> (oxygen/oxygen supplies covered 100%)	Covered at 85%; you pay 15% \$500 out of pocket maximum	\$500 benefit deductible; then covered at 50%
<b>Diabetic Testing Supplies</b> (Glucose monitors, test strips, and lancets)	Covered at 85%; you pay 15%	\$500 benefit deductible; then covered at 50%
<b>Home Health Care</b>	Covered at 100%	Covered at 80%; you pay 20%
<b>Physical, Speech, Occupational, and Cardiac Rehab Therapy</b> (per visit/per day/per provider)	\$15 copay	Covered at 80%; you pay 20%

## Emergent and Urgent Care

	Network	Out-of-Network
<b>Emergency Room Services</b> (Worldwide Coverage)	\$50 per visit	\$50 per visit
<b>Urgently Needed Care</b> (Worldwide Coverage; not emergency care; usually out of the service area)	\$50 or \$15 non-hospital	\$50 or \$15 non-hospital

**Medicare Covered Part B Drugs**

	<b>Network</b>	<b>Out-of-Network</b>
<b>Medicare Part B Drugs</b>	Covered at 90%; you pay 10% \$300 Quarterly Maximum	Covered at 80%; you pay 20% coinsurance of the lesser of the Out-of-Network charge or network allowed amount

**Inpatient Facility Services**

	<b>Network</b>	<b>Out-of-Network</b>
<b>Inpatient Hospital Care</b>	Covered at 100%	Covered at 80%; you pay 20%
<b>Skilled Nursing Facility Care</b> (100 days per Medicare benefit period)	Covered at 100%	Covered at 80%; you pay 20%

**Mental Health Services**

	<b>Network</b>	<b>Out-of-Network</b>
<b>Inpatient Psychiatric Hospital Care</b> (Limited to 190 days per lifetime)	Covered at 100%	Covered at 80%; you pay 20%
<b>Outpatient Mental Health/Psychiatric Services</b> (per individual or group session)	\$15 copay	Covered at 80%; you pay 20%
<b>Outpatient Chemical Dependency Substance Abuse Treatment</b> (per individual or group session)	\$15 copay	Covered at 80%; you pay 20%
<b>Outpatient Partial Hospitalization</b>	Covered at 100%	Covered at 80%; you pay 20%

## Prescription Drugs (Medicare Covered Part D Drugs)

<p><b>Initial Coverage Period</b>  <b>Until the total drug costs are \$4,830</b>          (Your share and FreedomBlue PPO share combined.)</p>	<p><b>For up to a 34-day retail supply:</b>          \$15 generic          \$30 preferred brand          \$60 non-preferred brand          \$60 Specialty Drug  <b>For up to a 90-day mail order supply:</b>          \$37.50 generic          \$75 preferred brand          \$150 non-preferred brand</p>	<p>Member responsible for paying the difference between the Out-of-Network retail price and the network allowed amount as well as network copayment.</p>
<p><b>Coverage Gap Period</b>          From <b>\$4,831</b> in <i>total drug costs</i> to <b>\$4,550</b> in total member out-of-pocket drug expenses (your cost sharing only)</p>	<p><b>For up to a 34-day retail supply:</b>          \$15 generic          \$30 preferred brand          \$60 non-preferred brand          \$60 Specialty Drug  <b>For up to a 90-day mail order supply:</b>          \$37.50 generic          \$75 preferred brand          \$150 non-preferred brand</p>	<p>Member will pay 100% at point of sale</p>
<p><b>Catastrophic Coverage Period</b>          After <b>\$4,550</b> in total member out-of-pocket drug expenses (your cost sharing only)</p>	<p><b>Member pays the greater of the following:</b>          5% member coinsurance          \$2.50 generic/multi-source brand          \$6.30 all other drugs</p>	

Notes:

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

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