

**2022 Freedom Blue PPO Summary of Benefits**

**Freedom Blue PPO (PA) In-Network**

**Freedom Blue PPO (PA) Out-of-Network**

**Important Information**

**Premium and Other Important Information**

You pay a monthly premium of \$235. In addition, you keep paying your Medicare Part B premium.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. For more information about Part B premiums based on income, visit [www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html](http://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html) or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

**Plan Deductible**

\$800

**In Network Out-of-Pocket Maximum**  
(does not include Part D Drugs)

\$1,600

**Combined In and Out-of-Network Out-of-Pocket Maximum**  
(does not include Part D Drugs)

\$3,400

**Covered Medical and Hospital Benefits**

**Note:**

Services with a 1 may require prior authorization.

**Inpatient Hospital Care<sup>1</sup>**

(includes Substance Abuse and Rehabilitation Services)

Our plan covers an unlimited number of days for an inpatient hospital stay.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

You pay: 15% Coinsurance for each stay.

You pay: 30% Coinsurance for each stay.

**Outpatient Hospital/Ambulatory Surgery Center<sup>1</sup>**

You pay: 15% Coinsurance

You pay: 30% Coinsurance

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<p><b>Doctor Office Visits</b></p> <p>Office visit copays do not apply to the annual deductible if applicable</p>	<p>You pay: \$15 Copay Primary Care Physician visit</p> <p>You pay: \$25 Copay Specialist visit</p>	<p>You pay: 30% Coinsurance Primary Care Physician visit</p> <p>You pay: 30% Coinsurance Specialist visit</p>
<p><b>Preventive Services</b></p>	<p>You pay: \$0 copay</p> <p>Our plan covers many preventive services, including: Abdominal Aortic Aneurysm Screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer Screening, Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes Screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots, Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p>	
<p><b>Emergency Care</b></p> <p>You may go to any emergency room if you reasonably believe you need emergency care.</p>	<p>You pay \$75 Copay for each emergency room visit.</p> <p>Worldwide coverage for emergency and urgently needed care.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.</p>	
<p><b>Urgent Care</b></p> <p>This is <b>not</b> emergency care</p>	<p>You pay: \$40 Copay</p>	

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<p><b>Diagnostic Tests, Lab, Radiology Services<sup>1</sup></b> Such as MRIs and CT Scans and X-rays</p>	<p>You pay: 15% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 15% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 15% Coinsurance for standard imaging services.</p> <p>You pay: 15% Coinsurance for advanced imaging services.</p> <p>You pay: \$0 Copay for therapeutic radiology services.</p>	<p>You pay: 30% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 30% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 30% Coinsurance for standard imaging services</p> <p>You pay: 30% Coinsurance for advanced imaging services.</p> <p>You pay: 30% Coinsurance for therapeutic radiology services.</p>
<p><b>Hearing Services</b> Medicare covered Exam to diagnose and treat hearing and balance issues</p>	<p>You pay: \$25 Copay</p>	<p>You pay: 30% Coinsurance</p>
<p><b>Hearing Services</b> Routine Exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum.</p>	<p>You pay: \$25 Copay</p> <p>\$499 copay per aid per year for TruHearing Advanced. \$799 copay per aid per year for TruHearing Premium.</p>	<p>You pay: 30% Coinsurance</p> <p>\$500 allowance for hearing aids every 3 years from any other provider.</p>
<p><b>Dental Services<sup>1</sup></b> Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.</p>	<p>Medicare covered dental benefits you pay: \$25 Copay.</p>	<p>Medicare covered dental benefits you pay: 30% Coinsurance.</p>
<p><b>Vision</b> Medicare covered Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p>	<p>You pay: \$25 Copay</p> <p>\$200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.</p>	<p>You pay: 30% Coinsurance</p> <p>\$200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.</p>

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<p><b>Routine Vision</b></p>	<p>Routine eye exam (for up to 1 every year) you pay: \$0 Copay</p> <p>Eye Wear Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full.</p> <p>A \$150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.</p>	<p>You pay: \$50 Copay for routine eye exams.</p> <p>A \$150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.</p>
<p><b>Mental Health Care<sup>1</sup></b></p> <p>Office visit copays do not apply to the annual deductible.</p>	<p>Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital .</p> <p>Inpatient stay you pay: 15% Coinsurance</p> <p>Outpatient group therapy visit you pay: \$25 Copay</p> <p>Outpatient individual therapy visit you pay: \$25 Copay</p>	<p>Inpatient stay you pay: 30% Coinsurance</p> <p>Outpatient group therapy visit you pay: 30% Coinsurance</p> <p>Outpatient individual therapy visit you pay: 30% Coinsurance</p>
<p><b>Skilled Nursing Facility (SNF)<sup>1</sup></b></p> <p>Medicare-certified skilled nursing facility</p>	<p>You pay: 15% Coinsurance per admission for days 1-100.</p> <p>No prior hospital stay is required.</p>	<p>You pay: 30% Coinsurance per admission for days 1-100.</p> <p>No prior hospital stay is required.</p>
<p><b>Physical Therapy<sup>1</sup></b></p>	<p>You pay: \$25 Copay for Medicare-covered Physical Therapy visits.</p>	<p>You pay: 30% Coinsurance for Medicare-covered Physical Therapy visits.</p>

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