Anthem Blue Cross
Health. Join In.

Summary of Benefits for Freedom Blue Plan I℠ (Regional PPO) and Freedom Blue Plus℠ (Regional PPO)

Available in California

A health plan with a Medicare contract.

M0013_10SB_004_R9943_001_003
09/29/2009_FINAL

SCASB2286BM 1009
CA

Section I: Introduction to the Summary of Benefits

Thank you for your interest in Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO). Our plans are offered by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health Insurance Company), a Medicare Advantage Preferred Provider Organization (PPO).

This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) and ask for the "Evidence of Coverage."

You Have Choices in Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare plan. Another option is a Medicare health plan, like Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may be able to join or leave a plan only at certain times. Please call Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) at the number listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) and the Original Medicare plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare plan covers.

Our members receive all of the benefits that the Original Medicare plan offers. We also offer more benefits, which may change from year to year.

Where Are Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) Available?

The service area for these plans includes the following counties:

California: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Eldorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo and Yuba counties.

You must live in one of these areas to join the plan.

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

Who Is Eligible to Join Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO)?

You can join Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with end-stage renal disease are generally not eligible to enroll in Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at our website.

Our customer service number is listed at the end of this introduction.

What Happens If I Go to a Doctor Who's Not in Your Network?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

Does My Plan Cover Medicare Part B or Part D Drugs?

Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join This Plan?

Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at **www.anthem.com/medicare**. Our customer service number is listed at the end of this introduction.

Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) have a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

What Is a Prescription Drug Formulary?

Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you, and you can see our

complete formulary on our website at **www.anthem.com/medicare**.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With My Prescription Drug Plan Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

What Are My Protections in This Plan?

All Medicare Advantage plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year.

Even if a Medicare Advantage plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance.

You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered.

If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision.

You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision.

Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service.

If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state:

Lumetra Health Services Advisory Group
1-800-841-1602

As a member of Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance.

You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered.

An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost.

You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug.

If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request.

If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state:

Lumetra Health Services Advisory Group
1-800-841-1602

What Is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) for more details.

What Types of Drugs May Be Covered Under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Freedom Blue Plan I (Regional PPO) or Freedom Blue Plus (Regional PPO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service).

If you have access to the Web, you may use the Web tools on **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area.

You can also call us directly at 1-877-811-3107 to obtain a copy of the plan ratings for this plan. TTY users call 1-877-247-1657.

Please Call Anthem Blue Cross Life and Health Insurance Company for More Information About Freedom Blue Plan I (Regional PPO) and Freedom Blue Plus (Regional PPO)

- Visit us at **www.anthem.com/medicare** or call us:
- **Customer Service Hours:** 8 a.m. to 8 p.m., 7 days a week
- **Current members should call, toll free, 1-877-811-3107** (TTY/TDD: 1-877-247-1657).
- **Prospective members should call, toll free, 1-888-211-9813** (TTY/TDD: 1-800-241-6894).
- **Current members should call, locally, 1-877-811-3107** (TTY/TDD: 1-877-247-1657).
- **Prospective members should call, locally, 1-888-211-9813** (TTY/TDD: 1-800-241-6894).
- **For more information about Medicare,** please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
- Or, visit **www.medicare.gov** on the Web.
- If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Anthem Blue Cross Life and Health Insurance Company for details.

Section II: Summary of Benefits

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
Important Information			
1. Premium and Other Important Information	In 2009 the monthly Part B Premium was $96.40 and will change for 2010 and the yearly Part B deductible amount was $135 and will change for 2010. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was $85,000 for singles, $170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** **$0 monthly plan premium in addition to your monthly Medicare Part B premium.** **In-Network** $3,350 out-of-pocket limit. All plan services included. **In and Out-of-Network** $500 yearly deductible. Contact the plan for services that apply. $3,350 out-of-pocket limit. In-Network: This limit includes only Medicare-covered services. Out-of-Network: This limit includes only Medicare-covered services.	**General** **$31 monthly plan premium in addition to your monthly Medicare Part B premium.** **In-Network** $3,350 out-of-pocket limit. All plan services included. **In and Out-of-Network** $500 yearly deductible. Contact the plan for services that apply. $3,350 out-of-pocket limit. In-Network: This limit includes only Medicare-covered services. Out-of-Network: This limit includes only Medicare-covered services.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
2. Doctor and Hospital Choice **(For more information, see Emergency - #15 and Urgently Needed Care - #16.)**	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** No referral required for network doctors, specialists, and hospitals. **Out-of-Network** Plan covers you when you travel in the U.S.	**In-Network** No referral required for network doctors, specialists, and hospitals. **Out-of-Network** Plan covers you when you travel in the U.S.

Summary of Benefits

Inpatient Care

3. Inpatient Hospital Care **(includes Substance Abuse and Rehabilitation Services)**	In 2009 the amounts for each benefit period were: ▪ Days 1 - 60: $1,068 deductible ▪ Days 61 - 90: $267 per day ▪ Days 91 - 150: $534 per lifetime reserve day These amounts will change for 2010. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a	**In-Network** $850 copay for each Medicare-covered hospital stay $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 15% of the cost for each hospital stay.	**In-Network** $850 copay for each Medicare-covered hospital stay $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 15% of the cost for each hospital stay.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
	new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.		
4. Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190-day lifetime limit in a psychiatric hospital.	**In-Network** $850 copay for each Medicare-covered hospital stay. You get up to 190 days in a psychiatric hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 15% of the cost for each hospital stay.	**In-Network** $850 copay for each Medicare-covered hospital stay. You get up to 190 days in a psychiatric hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** 15% of the cost for each hospital stay.
5. Skilled Nursing Facility (SNF) **(in a Medicare-certified skilled nursing facility)**	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: ▪ Days 1 - 20: $0 per day ▪ Days 21 - 100: $133.50 per day These amounts will change for 2010. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after	**General** Authorization rules may apply. **In-Network** For SNF stays: ▪ Days 1 - 20: $0 copay per day ▪ Days 21 - 100: $130 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	**General** Authorization rules may apply. **In-Network** For SNF stays: ▪ Days 1 - 20: $0 copay per day ▪ Days 21 - 100: $130 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
	one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**Out-of-Network** 30% of the cost for each SNF stay.	**Out-of-Network** 30% of the cost for each SNF stay.
6. Home Health Care **(includes medically-necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)**	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** 30% for home health visits.	**General** Authorization rules may apply. **In-Network** $0 copay for each Medicare-covered home health visit. **Out-of-Network** 30% for home health visits.
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice.
Outpatient Care			
8. Doctor Office Visits	20% coinsurance	**General** See "Physical Exams" for more information. **In-Network** $15 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care	**General** See "Physical Exams" for more information. **In-Network** $10 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $30 copay for each primary care doctor visit. $40 copay for each specialist visit.	Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits. **Out-of-Network** $25 copay for each primary care doctor visit. $40 copay for each specialist visit.
9. Chiropractic Services	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 30% of the cost for chiropractic benefits.	**General** Authorization rules may apply. **In-Network** $25 copay for each Medicare-covered visit. $20 copay for up to 20 routine visit(s) every year Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. **Out-of-Network** 30% to 50% of the cost for chiropractic benefits.
10. Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	**In-Network** $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Out-of-Network 30% of the cost for podiatry benefits.	**Out-of-Network** 30% of the cost for podiatry benefits.
11. Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual or group therapy visit. **Out-of-Network** 30% of the cost for mental health benefits. 30% of the cost for mental health benefits with a psychiatrist.	**General** Authorization rules may apply. **In-Network** $40 copay for each Medicare-covered individual or group therapy visit. **Out-of-Network** 30% of the cost for mental health benefits. 30% of the cost for mental health benefits with a psychiatrist.
12. Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual or group visits. **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.	**General** Authorization rules may apply. **In-Network** $40 copay for Medicare-covered individual or group visits. **Out-of-Network** 30% of the cost for outpatient substance abuse benefits.
13. Outpatient Services/ Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	**General** Authorization rules may apply.	**General** Authorization rules may apply.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		In-Network $100 copay for each Medicare-covered ambulatory surgical center visit. $25 to $250 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.	**In-Network** $100 copay for each Medicare-covered ambulatory surgical center visit. $25 to $200 copay for each Medicare-covered outpatient hospital facility visit. **Out-of-Network** 30% of the cost for ambulatory surgical center benefits. 30% of the cost for outpatient hospital facility benefits.
14. Ambulance Services **(medically-necessary ambulance services)**	20% coinsurance	**General** Authorization rules may apply. **In-Network** $175 copay for Medicare-covered ambulance benefits. **Out-of-Network** $175 copay for ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits. **Out-of-Network** $100 copay for ambulance benefits.
15. Emergency Care **(You may go to any emergency room if you reasonably believe you need emergency care.)**	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of	**General** $50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 72-hour(s) for the same condition, you pay $0 for the emergency room visit	**General** $50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 72-hour(s) for the same condition, you pay $0 for the emergency room visit

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
	the emergency room visit. NOT covered outside the U.S. except under limited circumstances.		
16. Urgently Needed Care **(This is NOT emergency care, and in most cases, is out of the service area.)**	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $35 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 72-hour(s) for the same condition, $0 for the urgent-care visit.	**General** $35 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 72-hour(s) for the same condition, $0 for the urgent-care visit.
17. Outpatient Rehabilitation Services **(Occupational Therapy, Physical Therapy, Speech and Language Therapy)**	20% coinsurance	**General** Authorization rules may apply. **In-Network** $25 to $50 copay for Medicare-covered occupational therapy visits. $25 to $50 copay for Medicare-covered physical and/or speech/language therapy visits. **Out-of-Network** 30% of the cost for occupational therapy benefits. 30% of the cost for physical and/or speech/language therapy visits.	**General** Authorization rules may apply. **In-Network** $25 to $50 copay for Medicare-covered occupational therapy visits. $25 to $50 copay for Medicare-covered physical and/or speech/language therapy visits. **Out-of-Network** 30% of the cost for occupational therapy benefits. 30% of the cost for physical and/or speech/language therapy visits.

Outpatient Medical Services and Supplies

18. Durable	20% coinsurance	**General** Authorization rules may	**General** Authorization rules may

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
Medical Equipment **(includes wheelchairs, oxygen, etc.)**		apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for durable medical equipment.	apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for durable medical equipment.
19. Prosthetic Devices **(includes braces, artificial limbs and eyes, etc.)**	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered items. **Out-of-Network** 30% of the cost for prosthetic devices.
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies **(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)**	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** $0 copay for diabetes self-monitoring training. $0 copay for nutrition therapy for diabetes. 20% of the cost for diabetes supplies. Separate office visit cost sharing of $15 to $25 copay may apply. **Out-of-Network** 30% of the cost for diabetes self-monitoring training. 30% of the cost for nutrition therapy for diabetes.	**In-Network** $0 copay for diabetes self-monitoring training. $0 copay for nutrition therapy for diabetes. 20% of the cost for diabetes supplies. Separate office visit cost sharing of $10 to $25 copay may apply. **Out-of-Network** 30% of the cost for diabetes self-monitoring training. 30% of the cost for nutrition therapy for diabetes.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		30% of the cost for diabetes supplies.	30% of the cost for diabetes supplies.
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically-necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $15 copay for Medicare-covered lab services. $25 to $150 copay for Medicare-covered diagnostic procedures and tests. $25 to $150 copay for Medicare-covered X-rays. $25 to $150 copay for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services. Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for diagnostic procedures, tests, and lab services. 30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays. $200 copay for diagnostic radiology services	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered lab services. $25 to $100 copay for Medicare-covered diagnostic procedures and tests. $25 to $100 copay for Medicare-covered X-rays. $25 to $100 copay for Medicare-covered diagnostic radiology services. 20% of the cost for Medicare-covered therapeutic radiology services. Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for diagnostic procedures, tests, and lab services. 30% of the cost for therapeutic radiology services 30% of the cost for outpatient X-rays. $150 copay for diagnostic radiology services

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
Preventive Services			
22. Bone Mass Measurement **(for people with Medicare who are at risk)**	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** $0 copay for Medicare-covered bone mass measurement Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for Medicare-covered bone mass measurement.	**In-Network** $0 copay for Medicare-covered bone mass measurement Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for Medicare-covered bone mass measurement.
23. Colorectal Screening Exam **(for people with Medicare age 50 and older)**	20% coinsurance Covered when you are high risk or when you are age 50 and older.	**In-Network** $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for colorectal screenings.	**In-Network** $0 copay for Medicare-covered colorectal screenings. Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for colorectal screenings.
24. Immunizations **(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, pneumonia vaccine)**	$0 copay for flu and pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.	**In-Network** $0 copay for flu and pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for flu and pneumonia vaccines. Separate office visit cost sharing of $15 to $25 may apply. No referral needed for other immunizations.	**In-Network** $0 copay for flu and pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for flu and pneumonia vaccines. Separate office visit cost sharing of $10 to $25 may apply. No referral needed for other immunizations.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Out-of-Network $0 copay for immunizations.	**Out-of-Network** $0 copay for immunizations.
25. Mammograms (Annual Screenings) **(for women with Medicare age 40 and older)**	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for screening mammograms.	**In-Network** $0 copay for Medicare-covered screening mammograms. Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for screening mammograms.
26. Pap Smears and Pelvic Exams **(for women with Medicare)**	$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for pelvic exams	**In-Network** $0 copay for Medicare-covered Pap smears and pelvic exams. Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for Pap smears and pelvic exams.	**In-Network** $0 copay for Medicare-covered Pap smears and pelvic exams. Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for Pap smears and pelvic exams.
27. Prostate Cancer Screening Exams **(for men with Medicare age 50 and older)**	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** $0 copay for Medicare-covered prostate cancer screening Separate office visit cost sharing of $15 to $25 may apply. **Out-of-Network** 30% of the cost for prostate cancer screening.	**In-Network** $0 copay for Medicare-covered prostate cancer screening Separate office visit cost sharing of $10 to $25 may apply. **Out-of-Network** 30% of the cost for prostate cancer screening.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
28. End-Stage Renal Disease	20% coinsurance for renal dialysis 20% coinsurance for nutrition therapy for end-stage renal disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**In-Network** 10% of the cost for renal dialysis $0 copay for nutrition therapy for end-stage renal disease **Out-of-Network** 30% of the cost for nutrition therapy for end-stage renal disease. 10% of the cost for renal dialysis.	**In-Network** 10% of the cost for renal dialysis $0 copay for nutrition therapy for end-stage renal disease **Out-of-Network** 30% of the cost for nutrition therapy for end-stage renal disease. 10% of the cost for renal dialysis.
29. Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage plan or a Medicare Cost plan that offers prescription drug coverage.	***Drugs Covered Under Medicare Part B*** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 25% of the cost for Part B drugs out-of-network. ***Drugs Covered Under Medicare Part D*** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at	***Drugs Covered Under Medicare Part B*** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 25% of the cost for Part B drugs out-of-network. ***Drugs Covered Under Medicare Part D*** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		www.anthem.com/ medicare on the Web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long-term care facilities, or ▪ have access to Indian / Tribal / Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue Plan I (Regional PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's	**www.anthem.com/ medicare** on the Web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long-term care facilities, or ▪ have access to Indian / Tribal / Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Freedom Blue Plus (Regional PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue Plan I (Regional PPO) approves the exception, you will pay Tier 3 Non-Preferred Brand & Certain Generic Drugs cost-sharing for that drug. **In-Network** $0 deductible. Some covered drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of drugs in this tier ▪ $21 copay for a three-month (90-day) supply of drugs in this tier	website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Freedom Blue Plus (Regional PPO) approves the exception, you will pay Non-Preferred Brand & Certain Generic Drugs cost-sharing for that drug. **In-Network** $0 deductible. Some covered drugs don't count toward your out-of-pocket drug costs. **Initial Coverage** You pay the following until total yearly drug costs reach $2,830: **Retail Pharmacy** ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of drugs in this tier ▪ $21 copay for a three-month (90-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Tier 2 Preferred Brand & Certain Generic Drugs ▪ $43 copay for a one-month (30-day) supply of drugs in this tier ▪ $129 copay for a three-month (90-day) supply of drugs in this tier ***Tier 3 Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (30-day) supply of drugs in this tier ▪ $255 copay for a three-month (90-day) supply of drugs in this tier ***Tier 4 Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier ***Tier 5 Specialty Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long-Term Care Pharmacy** ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month	***Preferred Brand & Certain Generic Drugs*** ▪ $43 copay for a one-month (30-day) supply of drugs in this tier ▪ $129 copay for a three-month (90-day) supply of drugs in this tier ***Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (30-day) supply of drugs in this tier ▪ $255 copay for a three-month (90-day) supply of drugs in this tier ***Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier ***Specialty Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Long-Term Care Pharmacy** ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (34-day) supply of drugs

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		(34-day) supply of drugs in this tier ***Tier 2 Preferred Brand & Certain Generic Drugs*** ▪ $43 copay for a one-month (34-day) supply of drugs in this tier ***Tier 3 Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (34-day) supply of drugs in this tier ***Tier 4 Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier ***Tier 5 Specialty Drugs*** ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** ***Tier 1 Preferred Generic Drugs*** ▪ $10.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $21 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy.	in this tier ***Preferred Brand & Certain Generic Drugs*** ▪ $43 copay for a one-month (34-day) supply of drugs in this tier ***Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (34-day) supply of drugs in this tier ***Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier ***Specialty Drugs*** ▪ 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Mail Order** ***Preferred Generic Drugs*** ▪ $10.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $21 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Tier 2 Preferred Brand & Certain Generic Drugs ▪ $107.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $129 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Tier 3 Non-Preferred Brand & Certain Generic Drugs*** ▪ $212.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $255 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Tier 4 Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Tier 5 Specialty Drugs*** ▪ 33% coinsurance for a one-month (30-day)	***Preferred Brand & Certain Generic Drugs*** ▪ $107.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $129 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Non-Preferred Brand & Certain Generic Drugs*** ▪ $212.50 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ $255 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. ***Specialty Drugs*** ▪ 33% coinsurance for a one-month (30-day)

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. **Coverage Gap** The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap. You pay the following: **Retail Pharmacy** ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of all drugs covered in this tier ▪ $21 copay for a three-month (90-day) supply of all drugs covered in this tier **Long-Term-Care Pharmacy** ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month (34-day) supply of all drugs covered in this tier	supply of drugs in this tier from a preferred mail-order pharmacy. ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail-order pharmacy. **Coverage Gap** The plan covers many generics (65%-99% of formulary generic drugs) AND few brands (less than 10% of formulary brand drugs) through the coverage gap. You pay the following: **Retail Pharmacy** ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of all drugs covered in this tier ▪ $21 copay for a three-month (90-day) supply of all drugs covered in this tier **Long-Term-Care Pharmacy** ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (34-day) supply of all drugs covered in this tier

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Mail Order ***Tier 1 Preferred Generic Drugs*** ▪ $10.50 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail-order pharmacy ▪ $21 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail-order pharmacy For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100%, until your yearly out-of-pocket drug costs reach $4,550. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: ▪ A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or ▪ 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your	**Mail Order** ***Preferred Generic Drugs*** ▪ $10.50 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail-order pharmacy ▪ $21 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail-order pharmacy For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100%, until your yearly out-of-pocket drug costs reach $4,550. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: ▪ A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or ▪ 5% coinsurance. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue Plan I (Regional PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug, minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of drugs in this tier ***Tier 2 Preferred Brand & Certain Generic Drugs*** ▪ $43 copay for a one-month (30-day) supply of drugs in this tier ***Tier 3 Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (30-day) supply of drugs in this tier ***Tier 4 Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier	normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Freedom Blue Plus (Regional PPO). **Out-of-Network Initial Coverage** You will be reimbursed up to the full cost of the drug, minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of drugs in this tier ***Preferred Brand & Certain Generic Drugs*** ▪ $43 copay for a one-month (30-day) supply of drugs in this tier ***Non-Preferred Brand & Certain Generic Drugs*** ▪ $85 copay for a one-month (30-day) supply of drugs in this tier ***Non-Specialty Injectable Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		Tier 5 Specialty Drugs ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug, minus the following: ***Tier 1 Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of all drugs covered in this tier ***Tier 2 Preferred Brand & Certain Generic Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plan I (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I (Regional PPO) so we can add the amounts you spent out-of-network to	***Specialty Drugs*** ▪ 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Out-of-Network Coverage Gap** You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug, minus the following: ***Preferred Generic Drugs*** ▪ $7 copay for a one-month (30-day) supply of all drugs covered in this tier ***Preferred Brand & Certain Generic Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plus (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plus (Regional PPO) so we can add the amounts you spent out-of-network to

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		your total out-of-pocket costs for the year. ***Tier 3 Non-Preferred Brand & Certain Generic Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plan I (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. ***Tier 4 Non-Specialty Injectable Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plan I (Regional PPO) for out-of-network	your total out-of-pocket costs for the year. ***Non-Preferred Brand & Certain Generic Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plus (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plus (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. ***Non-Specialty Injectable Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plus (Regional PPO) for out-of-network

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. ***Tier 5 Specialty Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plan I (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plan I (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network	purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plus (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. ***Specialty Drugs*** ▪ After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network, until your yearly out-of-pocket drug costs reach $4,550. ▪ You will not be reimbursed by Freedom Blue Plus (Regional PPO) for out-of-network purchases when you are in the coverage gap. ▪ However, you should still submit documentation to Freedom Blue Plus (Regional PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
		up to the full cost of the drug, minus the following: ▪ A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or ▪ 5% coinsurance.	up to the full cost of the drug, minus the following: ▪ A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or ▪ 5% coinsurance.
30. Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** In general, preventive dental benefits (such as cleaning) not covered. $0 copay for Medicare-covered dental benefits. **Out-of-Network** $0 copay for comprehensive dental benefits.	**In-Network** $0 copay for the following preventive dental benefits: ▪ up to one oral exam(s) every year ▪ up to one cleaning(s) every year $0 copay for Medicare-covered dental benefits. **Out-of-Network** $0 copay for comprehensive dental benefits. 20% of the cost for preventive dental benefits.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** In general, routine hearing exams and hearing aids not covered. $25 copay for Medicare-covered diagnostic hearing exams **Out-of-Network** 30% of the cost for hearing exams.	**In-Network** $0 copay for hearing aids. $25 copay for Medicare-covered diagnostic hearing exams $0 copay for up to one routine hearing test(s) every year $100 limit for hearing aids every two years.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
			Out-of-Network 30% of the cost for hearing exams. $0 copay for hearing aids.
32. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for ▪ one pair of eyeglasses or contact lenses after cataract surgery $25 copay for exams to diagnose and treat diseases and conditions of the eye. $20 copay for up to one routine eye exam(s) every year **Out-of-Network** $0 copay for eye wear. 20% to 30% of the cost for eye exams.	**In-Network** $0 copay for ▪ one pair of eyeglasses or contact lenses after cataract surgery ▪ up to one pair(s) of glasses every two years ▪ up to one pair(s) of contacts every two years $25 copay for exams to diagnose and treat diseases and conditions of the eye. $20 copay for up to one routine eye exam(s) every year $100 limit for eye glasses (lenses and frames) every two years. $80 limit for contact lenses every two years. Plan offers additional vision benefits. **Out-of-Network** $0 copay for eye wear. 20% to 30% of the cost for eye exams.
33. Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage When you get Medicare Part B, you can get a one	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.	**In-Network** $0 copay for routine exams. Limited to 1 exam(s) every year.

Benefit	Original Medicare	Freedom Blue Plan I (Regional PPO)	Freedom Blue Plus (Regional PPO)
	time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	**Out-of-Network** 30% of the cost for routine exams.	**Out-of-Network** 30% of the cost for routine exams.
Health/ Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	**In-Network** The plan covers the following health/wellness education benefits: ▪ health club membership/fitness classes ▪ nursing hotline $0 copay for each Medicare-covered smoking cessation counseling session. **Out-of-Network** $0 copay for health and wellness services.	**In-Network** The plan covers the following health/wellness education benefits: ▪ health club membership/fitness classes ▪ nursing hotline $0 copay for each Medicare-covered smoking cessation counseling session. **Out-of-Network** $0 copay for health and wellness services.
Transportation **(Routine)**	Not covered.	**In-Network** This plan does not cover routine transportation.	**In-Network** This plan does not cover routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover acupuncture.	**In-Network** $20 copay per visit up to 20 visit(s) every year. **Out-of-Network** 50% of the cost for acupuncture visits.