



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



The Pennsylvania State University

Questions? Call 1-866-918-5285

2010 FreedomBlue PFFS Benefit Summary

You must receive services from a Medicare participating provider. The provider must agree to Highmark's terms and conditions. No referrals are needed for specialty care.

Benefits	
	Network
Maximum Annual Out-of-Pocket	None
Lifetime Maximum	Unlimited
Annual Plan Deductible	None
Plan Co-Insurance	None

Preventive Care	
	What You Pay
Annual Physical Exam	\$10 copay for Primary Care Physician \$15 copay for Specialist
Preventative Screening PAP/Pelvic Exams	Covered at 100%
Preventive Screening Mammograms	Covered at 100%
Colorectal Preventive Screening Exams	Covered at 100%
Prostate Preventive Screening Exams	Covered at 100%
Bone Mass Measurement Preventive Screening Exams	Covered at 100%
Immunizations (Not covered for purposes of travel)	Covered at 100% Office visit cost sharing may apply

Vision Care (Davis Vision Network)

	What You Pay
Medicare-covered Vision Exam and Post-cataract Surgery Eyewear (Routine eye exams are not covered)	\$15 copay
	\$100 allowance for post-cataract surgery eyeglass frames per operated eye \$100 allowance for post-cataract surgery eyeglass lenses or contact lenses per operated eye.

Hearing Services

	What You Pay
Annual Routine Hearing Exam	\$15 copay
Hearing Aids	\$500 benefit maximum for one or more hearing aids every three years

Outpatient Services

	What You Pay
Primary Care Home/Office Visits	\$10 copay
Specialist Home/Office Visits	\$15 copay
Outpatient Surgery and Invasive Procedures (per visit/per day/per provider)	Covered at 100%
Diagnostic Procedures/Tests	Covered at 100%
Lab Services	Covered at 100%
X-Rays and Diagnostic Radiological Services	Covered at 100%

Supplies and Services	
	What You Pay
Ambulance (Emergent Services per one way trip)	\$100 Copay per trip
Ambulance (Non-emergent Services per one way trip; Requires a Physican Certification Statement)	\$100 Copay per trip
Durable Medical Equipment/Prosthetics/Orthotics (oxygen/oxygen supplies covered 100%)	Covered 100%
Diabetic Testing Supplies (Glucose monitors, test strips, and lancets)	Covered at 100%
Home Health Care	Covered at 100%
Physical, Speech, Occupational, and Cardiac Rehab Therapy (per visit/per day/per provider)	\$15 copay
Emergent and Urgent Care	
	What You Pay
Emergency Room Services (Worldwide Coverage)	\$50 per visit
Urgently Needed Care (Worldwide Coverage; not emergency care; usually out of the service area)	\$50 hospital or \$15 non-hospital
Medicare Covered Part B Drugs	
	What You Pay
Medicare Part B Drugs	\$12 Generic \$20 Preferred Brand \$40 Non Preferred \$50 Specialty
Inpatient Facility Services	
	What You Pay
Inpatient Hospital Care	Covered at 100%
Skilled Nursing Facility Care (100 days per Medicare benefit period)	Covered at 100%

Mental Health Services	
	What You Pay
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	Covered at 100%
Outpatient Mental Health/Psychiatric Services (per individual or group session)	\$15 copay
Outpatient Chemical Dependency Substance Abuse Treatment (per individual or group session)	\$15 copay
Outpatient Partial Hospitalization	100% covered
Prescription Drugs (Medicare Covered Part D Drugs)	
Drug Formulary	What You Pay
Initial Coverage Period Until the total drug costs are \$2,830 (Your share and FreedomBlue PFFS share combined.)	For up to a 34-day retail supply: \$12 generic \$20 preferred brand \$40 non-preferred brand \$50 Specialty Drug For up to a 90-day mail order supply: \$12 generic \$20 preferred brand \$40 non-preferred brand
Coverage Gap Period From \$2,831 in total drug costs to \$4,550 in total member out-of-pocket drug expenses (your cost sharing only)	For up to a 34-day retail supply: \$12 generic \$20 preferred brand \$40 non-preferred brand \$50 Specialty Drug For up to a 90-day mail order supply: \$12 generic \$20 preferred brand \$40 non-preferred brand
Catastrophic Coverage Period After \$4,550 in total member out-of-pocket drug expenses (your cost sharing only)	Member pays the greater of the following: 5% member coinsurance \$2.50 generic/multi-source brand \$6.30 all other drugs

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.

Part D Excluded Drugs

The following Part D drugs excluded drugs are covered with copays of: \$12 generic/\$20 preferred brand/\$40 non-preferred brand.

Alprazolam 0.25mg Tablets	Alprazolam 0.5mg Tablets	Alprazolam 1mg Tablets
Alprazolam 2mg Tablets	Clonazepam 0.5mg Tablets	Clonazepam 1mg Tablets
Clonazepam 2mg Tablets	Folic Acid 1mg Tablets	Levitra 10mg Tablets
Levitra 2.5mg Tablets	Levitra 20mg Tablets	Levitra 5mg Tablets
Lorazepam 0.5mg Tablets	Lorazepam 1mg Tablets	Lorazepam 2mg Tablets
Phenobarbital 100mg (#100) Tablets	Phenobarbital 100mg (#1000 Tablets)	Phenobarbital 15mg Tablets
Phenobarbital 16.2mg Tablets	Phenobarbital 30mg Tablets	Temazepam 15mg Tablets
Phenobarbital 32.4mg Tablets	Phenobarbital 60mg Tablets	Temazepam 30mg Tablets
Phenobarbital 64.8mg Tablets	Phenobarbital 97.2mg (#100) Tablets	Temazepam 7.5mg Tablets
Phenobarbital 97.2mg (1000) Tablets		

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