

# Western Pennsylvania Teamsters & Employers Welfare Fund

## 178473 High Option

### 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 \$269. 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

None

##### 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: \$50 Copay for each stay.

You pay: \$50 Copay for each stay.

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

You pay: \$25 Copay

You pay: \$25 Copay

Services with a 1 may require prior authorization

# Western Pennsylvania Teamsters Pension Fund

## 178474 Low Option

### 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 \$134. 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

\$1,000

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

\$2,400

##### 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: 10% Coinsurance for each stay.

You pay: 10% Coinsurance for each stay.

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

You pay: 10% Coinsurance

You pay: 10% Coinsurance

Services with a 1 may require prior authorization

<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: \$30 Copay Specialist visit</p>	<p>You pay: \$15 Copay Primary Care Physician visit</p> <p>You pay: \$30 Copay 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 \$50 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>	

<p><b>Doctor Office Visits</b></p> <p>Office visit copays do not apply to the annual deductible if applicable</p>	<p>You pay: \$25 Copay Primary Care Physician visit</p> <p>You pay: \$30 Copay Specialist visit</p>	<p>You pay: \$25 Copay Primary Care Physician visit</p> <p>You pay: \$30 Copay 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 \$50 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>	

<p><b>Diagnostic Tests, Lab, Radiology Services<sup>1</sup></b> Such as MRIs and CT Scans and X-rays</p>	<p>You pay: 0% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 0% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 0% Coinsurance for standard imaging services.</p> <p>You pay: 0% Coinsurance for advanced imaging services.</p> <p>You pay: \$0 Copay for therapeutic radiology services.</p>	<p>You pay: 0% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 0% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 0% Coinsurance for standard imaging services</p> <p>You pay: 0% Coinsurance for advanced imaging services.</p> <p>You pay: 0% 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: \$30 Copay</p>	<p>You pay: \$30 Copay</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: \$30 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 Copay</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: \$30 Copay.</p>	<p>Medicare covered dental benefits you pay: \$30 Copay.</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: \$30 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 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>

Services with a 1 may require prior authorization

<p><b>Diagnostic Tests, Lab, Radiology Services<sup>1</sup></b> Such as MRIs and CT Scans and X-rays</p>	<p>You pay: 10% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 10% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 10% Coinsurance for standard imaging services.</p> <p>You pay: 10% Coinsurance for advanced imaging services.</p> <p>You pay: \$0 Copay for therapeutic radiology services.</p>	<p>You pay: 10% Coinsurance for lab/diagnostic services in a physicians office or independent lab.</p> <p>You pay: 10% Coinsurance for lab/diagnostic services in an outpatient facility.</p> <p>You pay: 10% Coinsurance for standard imaging services</p> <p>You pay: 10% Coinsurance for advanced imaging services.</p> <p>You pay: 10% Coinsurance for therapeutic radiology services.</p>
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<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: \$30 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 Copay</p> <p>\$500 allowance for hearing aids every 3 years from any other provider.</p>
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Services with a 1 may require prior authorization

<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: \$50 Copay</p> <p>Outpatient group therapy visit you pay: \$30 Copay</p> <p>Outpatient individual therapy visit you pay: \$30 Copay</p>	<p>Inpatient stay you pay: \$50 Copay</p> <p>Outpatient group therapy visit you pay: \$30 Copay</p> <p>Outpatient individual therapy visit you pay: \$30 Copay</p>
<p><b>Skilled Nursing Facility (SNF)<sup>1</sup></b></p> <p>Medicare-certified skilled nursing facility</p>	<p>You pay: 0% Coinsurance per admission for days 1-100.</p> <p>No prior hospital stay is required.</p>	<p>You pay: 0% 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: \$30 Copay for Medicare-covered Physical Therapy visits.</p>	<p>You pay: \$30 Copay for Medicare-covered Physical Therapy visits.</p>

Services with a 1 may require prior authorization

<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: 10% Coinsurance</p> <p>Outpatient group therapy visit you pay: \$30 Copay</p> <p>Outpatient individual therapy visit you pay: \$30 Copay</p>	<p>Inpatient stay you pay: 10% Coinsurance</p> <p>Outpatient group therapy visit you pay: \$30 Copay</p> <p>Outpatient individual therapy visit you pay: \$30 Copay</p>
<p><b>Skilled Nursing Facility (SNF)<sup>1</sup></b></p> <p>Medicare-certified skilled nursing facility</p>	<p>You pay: 10% Coinsurance per admission for days 1-100.</p> <p>No prior hospital stay is required.</p>	<p>You pay: 10% 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: \$30 Copay for Medicare-covered Physical Therapy visits.</p>	<p>You pay: \$30 Copay for Medicare-covered Physical Therapy visits.</p>

Services with a 1 may require prior authorization

<p><b>Ambulance Services<sup>1</sup></b> Medically necessary ambulance services</p>	<p>You pay: \$75 Copay</p>	<p>Emergency - You pay: \$75 Copay</p> <p>Non-Emergency - You pay: 20% Coinsurance</p>
<p><b>Transportation (Routine)<sup>1</sup></b> Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.</p>	<p>You pay: \$10 Copay per trip.</p>	<p>You pay: 50% Coinsurance for out-of-network transportation services.</p>
<p><b>Part B Drugs<sup>1</sup></b> Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs.  In-network Part B covered chemotherapy drugs and other in-network Part B covered Drugs</p>	<p>You pay: 10% of the total cost up to a \$300 quarterly maximum</p>	<p>You pay: 10% of the total cost up to a \$300 quarterly maximum</p>
<p><b>Acupuncture</b> Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain</p>	<p>You pay: \$30 Copay for Medicare-covered Acupuncture visits.</p>	<p>You pay: \$30 Copay for Medicare-covered Acupuncture visits.</p>
<p><b>Chiropractic Care<sup>1</sup></b> Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)</p>	<p>You pay: \$20 Copay</p>	<p>You pay: \$30 Copay</p>
<p><b>Diabetes Supplies and Services<sup>1</sup></b> includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes</p>	<p>You pay: 15% Coinsurance</p> <p>Diabetes self-management training you pay: \$0 Copay.</p> <p>If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p>	<p>You pay: 20% Coinsurance</p>

Services with a 1 may require prior authorization

<p><b>Ambulance Services<sup>1</sup></b> Medically necessary ambulance services</p>	<p>You pay: 10% Coinsurance</p>	<p>Emergency - You pay: 10% Coinsurance</p> <p>Non-Emergency - You pay: 20% Coinsurance</p>
<p><b>Transportation (Routine)<sup>1</sup></b> Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.</p>	<p>You pay: \$10 Copay per trip.</p>	<p>You pay: 50% Coinsurance for out-of-network transportation services.</p>
<p><b>Part B Drugs<sup>1</sup></b> Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs.</p> <p>In-network Part B covered chemotherapy drugs and other in-network Part B covered Drugs</p>	<p>You pay: 10% Coinsurance</p>	<p>You pay: 10% Coinsurance</p>
<p><b>Acupuncture</b> Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain</p>	<p>You pay: \$30 Copay for Medicare-covered Acupuncture visits.</p>	<p>You pay: \$30 Copay for Medicare-covered Acupuncture visits.</p>
<p><b>Chiropractic Care<sup>1</sup></b> Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)</p>	<p>You pay: \$20 Copay</p>	<p>You pay: \$30 Copay</p>
<p><b>Diabetes Supplies and Services<sup>1</sup></b> includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes</p>	<p>You pay: 10% Coinsurance</p> <p>Diabetes self-management training you pay: \$0 Copay.</p> <p>If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p>	<p>You pay: 20% Coinsurance</p>

Services with a 1 may require prior authorization

<p><b>Durable Medical Equipment<sup>1</sup></b> Includes wheelchairs, prosthetics, oxygen, etc.</p>	<p>You pay: 15% Coinsurance for durable medical equipment.</p> <p>You pay: 15% Coinsurance for oxygen and oxygen supplies.</p>	<p>You pay: 20% Coinsurance for durable medical equipment.</p> <p>You pay: 20% Coinsurance for oxygen and oxygen supplies.</p>
<p><b>Foot Care (<i>podiatry services</i>)</b> Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.</p>	<p>You pay: \$30 Copay</p>	<p>You pay: \$30 Copay</p>
<p><b>Home Health Care<sup>1</sup></b></p>	<p>You pay: 0% Coinsurance</p>	<p>You pay: 0% Coinsurance</p>
<p><b>Outpatient Rehabilitation<sup>1</sup> Cardiac Rehabilitation</b> (maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks), <b>Occupational Therapy, Physical Therapy, Speech and Language Therapy</b></p>	<p>You pay: \$0 Copay for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>	<p>You pay: 0% Coinsurance for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>
<p><b>Over the Counter Drug Allowance</b></p>	<p>Not Covered</p>	
<p><b>Renal Dialysis</b> Services to Treat Kidney Disease</p>	<p>You pay: \$0 Copay</p>	<p>You pay: 20% Coinsurance</p>
<p><b>Wellness/Education and Other Supplemental Benefits &amp; Services</b></p>	<p>The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes</p>	<p>You pay: 50% of the cost for out-of-network health/wellness services after a \$500 deductible.</p>
<p><b>Hospice</b></p>	<p>You pay: \$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>	

Services with a 1 may require prior authorization

<p><b>Durable Medical Equipment<sup>1</sup></b> Includes wheelchairs, prosthetics, oxygen, etc.</p>	<p>You pay: 10% Coinsurance for durable medical equipment.</p> <p>You pay: 10% Coinsurance for oxygen and oxygen supplies.</p>	<p>You pay: 20% Coinsurance for durable medical equipment.</p> <p>You pay: 20% Coinsurance for oxygen and oxygen supplies.</p>
<p><b>Foot Care (<i>podiatry services</i>)</b> Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.</p>	<p>You pay: \$30 Copay</p>	<p>You pay: \$30 Copay</p>
<p><b>Home Health Care<sup>1</sup></b></p>	<p>You pay: 10% Coinsurance</p>	<p>You pay: 10% Coinsurance</p>
<p><b>Outpatient Rehabilitation<sup>1</sup> Cardiac Rehabilitation</b> (maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks), <b>Occupational Therapy, Physical Therapy, Speech and Language Therapy</b></p>	<p>You pay: \$0 Copay for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>	<p>You pay: 0% Coinsurance for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 Copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>
<p><b>Over the Counter Drug Allowance</b></p>	<p>Not Covered</p>	
<p><b>Renal Dialysis</b> Services to Treat Kidney Disease</p>	<p>You pay: \$0 Copay</p>	<p>You pay: 20% Coinsurance</p>
<p><b>Wellness/Education and Other Supplemental Benefits &amp; Services</b></p>	<p>The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes</p>	<p>You pay: 50% of the cost for out-of-network health/wellness services after a \$500 deductible.</p>
<p><b>Hospice</b></p>	<p>You pay: \$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>	

Services with a 1 may require prior authorization

# 178473 High

# Part D Prescription Drug Benefits

You pay the following until total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug cost paid by both you and a part D plan.

<b>DRUG</b>	<b>Initial Coverage</b>	<b>Preferred Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply
			Tier 1 (Preferred Generic Drugs)	\$10 Copay	\$30 Copay
			Tier 2 (Generic Drugs)	\$10 Copay	\$30 Copay
			Tier 3 (Preferred Brand Drugs and Generics)	\$25 Copay	\$75 Copay
			Tier 4 (Non-Preferred Drugs)	\$55 Copay	\$165 Copay
			Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available
		<b>Network Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply
			Tier 1 (Preferred Generic Drugs)	\$15 Copay	\$45 Copay
			Tier 2 (Generic Drugs)	\$15 Copay	\$45 Copay
	Tier 3 (Preferred Brand Drugs and Generics)		\$30 Copay	\$90 Copay	
	Tier 4 (Non-Preferred Drugs)		\$60 Copay	\$180 Copay	
	<b>Mail Order</b>	Tier	Up to 90 Day Supply		
		Tier 1 (Preferred Generic Drugs)	\$25 Copay		
		Tier 2 (Generic Drugs)	\$25 Copay		
		Tier 3 (Preferred Brand Drugs and Generics)	\$62.50 Copay		
		Tier 4 (Non-Preferred Drugs)	\$137.50 Copay		
		Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply		
	<b>Coverage Gap</b>	<b>Preferred Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply
Tier 1 (Preferred Generic Drugs)			\$10 Copay	\$30 Copay	
Tier 2 (Generic Drugs)			\$10 Copay	\$30 Copay	
Tier 3 (Preferred Brand Drugs and Generics)			\$25 Copay	\$75 Copay	
Tier 4 (Non-Preferred Drugs)			\$55 Copay	\$165 Copay	
Tier 5 (Specialty drugs consist of both Generic and Brand)			33% of the cost	Not Available	
<b>Network Retail Pharmacy</b>		Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic Drugs)	\$15 Copay	\$45 Copay	
		Tier 2 (Generic Drugs)	\$15 Copay	\$45 Copay	
		Tier 3 (Preferred Brand Drugs and Generics)	\$30 Copay	\$90 Copay	
		Tier 4 (Non-Preferred Drugs)	\$60 Copay	\$180 Copay	
<b>Mail Order</b>		Tier	Up to 90 Day Supply		
		Tier 1 (Preferred Generic Drugs)	\$25 Copay		
		Tier 2 (Generic Drugs)	\$25 Copay		
		Tier 3 (Preferred Brand Drugs and Generics)	\$62.50 Copay		
		Tier 4 (Non-Preferred Drugs)	\$137.50 Copay		
		Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost for a 31 day limit supply		
The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430. You will remain in the coverage gap until your costs (includes the 70% manufacturer discount) total \$7,050. Not everyone will enter the coverage gap.					
<b>Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of 5% of the cost or \$3.95 copayment for a generic \$9.85 copayment for all other drugs.				
<b>Formulary</b>	Incentive				

For questions about this plan's benefits or costs, please contact Freedom Blue PPO (PA). Call 1-866-456-7739, (TTY users call 711), seven days a week, between 8 a.m. and 8 p.m. EST. Please have Reference Code 22FB178473 ready when you call.

You pay the following until total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug cost paid by both you and a part D plan.

<b>DRUG</b>	<b>Initial Coverage</b>	<b>Preferred Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply
			Tier 1 (Preferred Generic Drugs)	\$10 Copay	\$30 Copay
			Tier 2 (Generic Drugs)	\$10 Copay	\$30 Copay
			Tier 3 (Preferred Brand Drugs and Generics)	\$35 Copay	\$105 Copay
			Tier 4 (Non-Preferred Drugs)	\$85 Copay	\$255 Copay
			Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available
		<b>Network Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply
			Tier 1 (Preferred Generic Drugs)	\$15 Copay	\$45 Copay
			Tier 2 (Generic Drugs)	\$15 Copay	\$45 Copay
	Tier 3 (Preferred Brand Drugs and Generics)		\$40 Copay	\$120 Copay	
	Tier 4 (Non-Preferred Drugs)		\$90 Copay	\$270 Copay	
	<b>Mail Order</b>	Tier	Up to 90 Day Supply		
		Tier 1 (Preferred Generic Drugs)	\$25 Copay		
		Tier 2 (Generic Drugs)	\$25 Copay		
		Tier 3 (Preferred Brand Drugs and Generics)	\$87.50 Copay		
Tier 4 (Non-Preferred Drugs)		\$212.50 Copay			
Tier 5 (Specialty drugs consist of both Generic and Brand)		33% of the cost for a 31 day limit supply			
<b>Coverage Gap</b>	<b>Preferred Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic Drugs)	\$10 Copay	\$30 Copay	
		Tier 2 (Generic Drugs)	\$10 Copay	\$30 Copay	
		Tier 3 (Preferred Brand Drugs and Generics)	\$35 Copay	\$105 Copay	
		Tier 4 (Non-Preferred Drugs)	\$85 Copay	\$255 Copay	
		Tier 5 (Specialty drugs consist of both Generic and Brand)	33% of the cost	Not Available	
	<b>Network Retail Pharmacy</b>	Tier	31 Day Supply	90 Day Supply	
		Tier 1 (Preferred Generic Drugs)	\$15 Copay	\$45 Copay	
		Tier 2 (Generic Drugs)	\$15 Copay	\$45 Copay	
		Tier 3 (Preferred Brand Drugs and Generics)	\$40 Copay	\$120 Copay	
		Tier 4 (Non-Preferred Drugs)	\$90 Copay	\$270 Copay	
	<b>Mail Order</b>	Tier	Up to 90 Day Supply		
		Tier 1 (Preferred Generic Drugs)	\$25 Copay		
		Tier 2 (Generic Drugs)	\$25 Copay		
		Tier 3 (Preferred Brand Drugs and Generics)	\$87.50 Copay		
Tier 4 (Non-Preferred Drugs)		\$212.50 Copay			
Tier 5 (Specialty drugs consist of both Generic and Brand)		33% of the cost for a 31 day limit supply			
The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430. You will remain in the coverage gap until your costs (includes the 70% manufacturer discount) total \$7,050. Not everyone will enter the coverage gap.					
<b>Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of 5% of the cost or \$3.95 copayment for a generic \$9.85 copayment for all other drugs.				
<b>Formulary</b>	Incentive				

For questions about this plan's benefits or costs, please contact Freedom Blue PPO (PA). Call 1-866-456-7739, (TTY users call 711), seven days a week, between 8 a.m. and 8 p.m. EST. Please have Reference Code 22FB178474 ready when you call.