

## 2012 MHS Signature 65 vs. FreedomBlue Comparison

### MEDICARE PART A COVERED SERVICES

**Inpatient Hospital** (Medicare inpatient mental health care coverage in a psychiatric facility is limited to 190 inpatient hospital days in a lifetime)

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Days 1 – 60</b>  <b>Days 61 – 90</b>  <b>Days 91 – 150</b>  For 60 Medicare lifetime reserve days that may be used only once  Additional Inpatient Hospital Days	Plan pays \$260 dollars toward the Medicare Part A deductible.  Plan pays \$65 dollars per day  Plan pays \$130 dollars per day  100% of Medicare eligible expenses for 365 days per benefit period after the 60 Medicare inpatient lifetime reserve days are exhausted.	100% coverage  (Includes Acute, Long-Term Acute, Mental Health, Substance Abuse/Rehab, and Physical Rehab)  190 days lifetime limit on Mental Health	80% coverage after plan deductible
<b>Emergency Services provided outside of the United States</b>	100% of the Provider's Reasonable Charge	\$50 co-payment (waived if admitted inpatient within 3 days for the same condition)	
<b>Blood</b>	First three pints per calendar year	100% coverage	80% coverage after plan deductible

### Skilled Nursing Facility Care

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Days 21 to 100</b>	Medicare Part A coinsurance	100% coverage (100 days per benefit period)	80% coverage after plan deductible
<b>Day 101 and beyond</b>	Not covered by this program	Not covered by this program	Not covered by this program

### MEDICARE PART B COVERED SERVICES

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Deductible</b>	This plan pays \$75 of the Part B deductible	\$0 deductible	\$250 deductible
<b>Coinsurance</b>	Medicare Part B coinsurance	100% coverage	80% coverage after plan deductible

**MEDICARE PART B COVERED SERVICES (continued)**

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Out of Pocket Maximum</b>	Not Applicable	\$3,400 <i>Total In and Out of Network Pocket Maximum</i>	

**Therapy Services**

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Outpatient Physical</b> (per therapy type/per day/per provider)	Medicare Part B coinsurance	\$15 co-payment	80% coverage after plan deductible
<b>Therapy Outpatient</b> (per therapy type/per day/per provider)	Medicare Part B coinsurance	\$15 co-payment	80% coverage after plan deductible
<b>Occupational Therapy</b> (per therapy type/per day/per provider)	Medicare Part B coinsurance	\$15 co-payment	80% coverage after plan deductible
<b>Outpatient Speech Therapy</b> (per therapy type/per day/per provider)	Medicare Part B coinsurance	\$15 co-payment	80% coverage after plan deductible
<b>Durable Medical Equipment</b>	Medicare Part B coinsurance	100% coverage	50% coverage
<b>Outpatient Hospital Services</b> (except Outpatient Psychiatric Treatment)	Medicare Part B coinsurance	100% coverage	80% coverage after plan deductible
<b>Outpatient Psychiatric Treatment</b>	Medicare Part B coinsurance	\$15 co-payment	80% coverage after plan deductible
<b>Blood</b>	First 3 pints per calendar year	100% coverage	80% coverage after plan deductible
<b>Outpatient Prescription Drugs (used in Immunosuppressive Therapy)</b>	Medicare Part B coinsurance	100% coverage	80% coverage after plan deductible <i>Member pays 20% coinsurance of the lesser of the OON charge or network allowed amount</i>

**Emergency Care**

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Emergency Accident Care</b>	Medicare Part B coinsurance	\$50 co-payment Waived if admitted inpatient within 3 days for the same condition Out of network co-payments do not apply to plan deductible	
<b>Emergency Medical Care</b>	Medicare Part B coinsurance	\$50 co-payment Waived if admitted inpatient within 3 days for the same condition Out of network co-payments do not apply to plan deductible	

## MEDICARE PART B COVERED SERVICES (continued)

### Preventive Services

Service	Plan Pays	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Mammogram Screening</b>	Medicare Part B coinsurance  Not subject to Medicare Part B deductible	100% coverage (Office visit cost sharing may apply)  Women 40 and older One baseline visit for women ages 35-39	
<b>Gynecological Services</b>	Medicare Part B coinsurance  Not subject to Medicare Part B deductible	100% coverage (Office visit cost sharing may apply)  Women 40 and older One baseline visit for women ages 35-39	
<b>Colorectal Cancer Screening</b>	Medicare Part B coinsurance	100% coverage (Office visit cost sharing may apply)	
<b>Bone Mass Measurements</b>	Medicare Part B coinsurance	100% coverage for procedure (Office visit cost sharing may apply)	
<b>Prostate Cancer Screening</b>	Medicare Part B coinsurance	100% coverage for procedure (Office visit cost sharing may apply)  (Digital rectal exam and PSA test every 12 months for men ages 50 and older)	

### MAJOR MEDICAL BENEFIT PROVISIONS

Service	Coverage	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Deductible Per Calendar Year Individual Family</b>	\$250 Individual	\$0 Individual	\$250 Individual
<b>Payment Level (based on provider's reasonable charge)</b>	80% PRC after deductible	100% coverage	80% coverage after plan deductible
<b>Out-of-Pocket Limit (Individual Family)</b>	\$0	\$3,400 <i>Total In and Out of Network Pocket Maximum</i>	
<b>Lifetime Maximum</b>	\$200,000/person	Unlimited	Unlimited
<b>Ambulance</b>	Not Covered	100% coverage	100% coverage  80% coverage for non-emergent services after plan deductible (Maximum Annual Coinsurance does not apply)
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered	Not Covered
<b>Diabetes Treatment</b>	Not Covered	100% coverage for procedure (Office visit cost sharing may apply)	100% coverage for procedure (Office visit cost sharing may apply)

**MAJOR MEDICAL BENEFIT PROVISIONS (continued)**

Service	Coverage	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Diagnostic Services Lab, X-ray and Medical Tests</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	Not Covered	100% coverage	50% coverage
<b>Emergency Room Services Facility Services</b>	Not Covered	\$50 co-payment (waived if admitted inpatient within 3 days for the same condition)	
<b>Enteral Formulae</b>	Not Covered	100% coverage	
<b>Annual Routine Hearing Exam</b>	Not Covered	\$15 co-payment	80% coverage after plan deductible  (balance billing allowed)  Plan deductible and maximum annual coinsurance do not apply
<b>Annual Routine Hearing Exam</b>	Not Covered	\$15 copay	80% coverage after plan deductible
		Covered up to \$500 for one or more hearing aids every three years	
<b>Annual Routine Vision Exam</b>	Not Covered	\$15 copay	80% coverage after plan deductible
		Standard eyeglass lenses and frames or contact lenses are covered in full every two years \$100 benefit maximum applies to non-standard frames or specialty contact lenses	
<b>Home Health Care Excludes Respite Care</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Hospice</b> <i>Includes Respite Care</i>	Not Covered	Medicare Covered	Medicare Covered
<b>Hospital Expenses Inpatient and Outpatient</b>	80% PRC after deductible	100% coverage  (Includes Acute, Long-Term Acute, Mental Health, Substance Abuse/Rehab, and physical rehab)  190 days lifetime limit on Mental Health	80% coverage after plan deductible
<b>Infertility Counseling, Testing and Treatment</b>	Not Covered	Not Covered	Not Covered
<b>Maternity</b>	Not Covered	Not Covered	Not Covered
<b>Medical Care Includes Inpatient Visits and Consultations</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Office Visits (PCP)</b>	Not Covered	\$10 co-payment	80% coverage after plan deductible

**MAJOR MEDICAL BENEFIT PROVISIONS (continued)**

Service	Coverage	FreedomBlue In-Network	FreedomBlue Out-of-Network
<b>Oral Surgery</b>	Not Covered	Not covered	Not covered
<b>Physical Therapy Outpatient</b>	Not Covered	\$15 co-payment	80% coverage after plan deductible
<b>Private Duty Nursing (Not Custodial Care)</b>	80% PRC after deductible	100% coverage Office visit copay may apply	80% coverage after plan deductible
<b>Psychiatric Care Services - Inpatient</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Psychiatric Care Services - Outpatient</b>	Not Covered	\$15 co-payment	80% coverage after plan deductible
<b>Skilled Nursing Care</b>	80% PRC after deductible <i>After the 100th day, charges for Skilled Nursing Facilities are covered under Major Medical for an additional 120 days.</i>	Not Covered after 100 <sup>th</sup> Day	
<b>Speech and Occupational Therapy Outpatient</b>	Not Covered	\$15 co-payment	80% coverage after plan deductible
<b>Substance Abuse - Detoxification</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Substance Abuse - Inpatient Rehabilitation</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Substance Abuse - Outpatient</b>	Not Covered	\$15 co-payment	80% coverage after plan deductible
<b>Surgical Expenses Includes Assistant Surgery, Anesthesia,</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Therapy Services Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiration Therapy</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Transplant Services</b>	Not Covered	100% coverage	80% coverage after plan deductible
<b>Condition Management</b>	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management	Case Management, Blues On Call, and Disease State Management

<b>PHARMACY BENEFIT</b> <i>(administered by Medco)</i>				
	<b>RETAIL</b>	<b>MAIL</b>	<b>FREEDOMBLUE RETAIL</b>	<b>FREEDOMBLUE MAIL</b>
<b>Benefit Period</b>	Calendar Year		Calendar Year	
<b>Deductible</b>	\$300/ individual		None	
<b>Out of Pocket Limit</b>	Not Applicable		Benefit changes to CMS Catastrophic level at \$4,700.00	
<b>Generic Prescription Drug</b>	Member pays 20% coinsurance - based on the provider's allowable price	\$20 copayment	\$8 generic	\$16 generic
<b>Brand Prescription Drug</b>	Member pays 40% coinsurance - based on the provider's allowable price	\$60 copayment	\$20 preferred brand	\$40 preferred brand
<b>Brand Non-Formulary Prescription Drug</b>	Member pays 40% coinsurance - based on the provider's allowable price	\$80 copayment	\$50 non-preferred brand/ \$50 Specialty Drug	\$100 non-preferred brand \$100 Specialty Drug
<b>Minimum/Maximum</b>	\$10 min/\$100 max	Not Applicable	Not Applicable	
<b>Formulary</b>	Incentive		Incentive	
<b>Generic Substitution (Soft)</b>	When you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed.		When you purchase a brand name drug that has a generic equivalent, you will be responsible for the brand non-preferred copayment.	
<b>Claim Submission</b>	Pharmacy Files at Point-of-Sale		Pharmacy Files at Point-of-Sale	
<b>Non-Network Pharmacy</b>	Not Covered	Not Covered	Not Covered <i>Certain exceptions may apply; please reference your Evidence of Coverage</i>	
<b>Prescription Drug Categories</b>				
<b>Contraceptives (oral and injectable)</b>	Not Covered		Not Covered	
<b>Fertility Agents</b>	Covered		Not Covered	
<b>Fluoride Products</b>	Covered		Not Covered	
<b>Insulin and Diabetic Supplies</b>	Covered		Not Covered	
<b>Smoking Deterrents (prescription)</b>	Covered		Not Covered	
<b>Vitamins (prescription)</b>	Covered		Not Covered	
<b>Weight Loss Drugs</b>	Covered		Not Covered	
<b>Allergy Serum</b>	Not Covered		Not Covered	

***For more specific information about the benefits under the FreedomBlue Medicare Advantage program, please refer to your Evidence of Coverage.***