New for 2014

For Medicare Eligible
Goodyear Trust Participants

FREEDOM BLUE PPO

The Great Benefits You Deserve

Plus

Lower Monthly Cost
Decreased Yearly Deductible
Additional Coverage

HIGHMARK. | Freedom Blue PPO

GOODYEAR
RETIREE HEALTHCARE TRUST

REFERENCE CODE 14FB3066

New for 2014

For Medicare Eligible Goodyear Trust Participants

Freedom Blue PPO

Backed by the strength and stability of Blue Cross Blue Shield

Freedom Blue PPO plan offers access to one of the largest networks coast to coast, access to all participating Blue Cross Blue Shield Medicare Advantage PPO networks, ***plus*** worldwide coverage for urgent and emergency care.

Freedom Blue PPO gives you more benefits:

- **Lower yearly deductible**
- **Award-winning SilverSneakers fitness program, that includes membership at thousands of participating fitness centers**
- **No referrals to see a specialist—ever**
- **Coverage for podiatry services, hearing aids, routine vision services and more**

		Freedom Blue PPO In-Network	Freedom Blue PPO Out-of-Network	2014 Medicare National PPO In-Network	2014 Medicare National PPO Out-of-Network
BASED ON INDIVIDUAL ENROLLMENT	Plan Deductible	$150		$400	$1,200
	Plan Coinsurance	5%	10%	10%	30%
	Out-of-Pocket Maximum	$1,500	Not Applicable	$1,800	$5,400
	Total In- and Out-of-Network Out-of-Pocket Maximum	$4,500		Does Not Apply	
	Lifetime Maximum	Unlimited		$2,000,000	
OUTPATIENT CARE	Physician Office Visit*	$25 Copay (PCP) $35 Copay (Specialist)	10%	$25 Copay (PCP) $35 Copay (Specialist)	30%
	Therapy Services	$25 Copay	10%	$25 Copay	30%
	Preventive Tests/Screenings	Covered in Full	Covered in Full	Covered in Full	Not Covered
	Diagnostic Tests, X-Rays, Lab Services, Radiology Services	5%	10%	10%	30%
	Outpatient Surgery	5%	10%	10%	30%
	Chiropractic Services*	$20 Copay for each Medicare-covered visit	10%	$25 Copay for each Medicare-covered visit	30%
	Podiatry Services*	$35 Copay for each Medicare-covered visit	10%	Not Covered	Not Covered
	Outpatient Mental Health Care*	$35 Copay	10%	$35 Copay	30%
INPATIENT AND EMERGENCY CARE	Ambulance Services	Covered in Full		Covered in Full	
	Emergency Care	$65 Copay		$100 Copay	
	Urgent Care Clinic	$35 Copay		$35 Copay	
	Inpatient Hospital	5%	10%	10%	30%
	Skilled Nursing Facility *(Days 1-100 per Benefit Period)*	5%	10%	10%	30%
SUPPLIES AND ADDITIONAL SERVICES	Medicare Part B Drugs	5%	10%	10%	30%
	Durable Medical Equipment	5%	10%	90% after network deductible	
	Routine Vision Services**	$35 Copay for an annual routine eye exam Standard eyeglass lenses and frames or contact lenses are covered in full every two calendar years A $100 benefit maximum for non-standard frames or specialty contact lenses every two years	10% for an annual routine eye exam $100 benefit maximum for specialty frames or specialty contact lenses every two years	100% coverage for exam but no coverage for routine eyeglasses or contact lenses	Not Covered
	Routine Hearing Services**	$35 Copay for an annual routine hearing exam	10% for an annual routine hearing exam	100% coverage for an annual routine hearing exam	Not Covered
	Hearing Aids**	$500 benefit maximum every three years		Not Covered	
	SilverSneakers Fitness Program	Covered in Full	Not Covered	Not Covered	

* Office visit copays are not applied to In-Network Out-of-Pocket Maximum, but are applied to the Total In- and Out-of-Network Out-of-Pocket Maximum.

** Routine Vision and Hearing cost sharing is not applied to the Plan Deductible or Out-of-Pocket Maximums.