

This is only a summary of your plan's benefits. See your Evidence of Coverage for more detailed information.



2021 Benefit Summary

Freedom Blue PPO no RX

199715

Retirees of the GoodyearTire & Rubber Company

In Network

Out Of Network

Deductible	\$500	
In Network Member Out-of-Pocket Maximum (For Medicare-covered services, not including Part D drugs)	\$3,000	N/A
Combined In and Out-of-Network Member Out-of-Pocket Maximum (for Medicare-covered services, not including Part D drugs)	\$6,000	
Annual Physical Exam	Covered in Full	Covered in Full
Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full
Doctor Office Visit	\$25 Copay	10% Coinsurance
Specialist Office Visit	\$35 Copay	10% Coinsurance
Advanced Imaging (Examples: CT Scans, MRI)	5% Coinsurance	10% Coinsurance
Standard Imaging (Examples: X-ray, Mammogram)	5% Coinsurance	10% Coinsurance
Diagnostic Testing (Example: Blood Work)	5% Coinsurance	10% Coinsurance
Outpatient Surgery	5% Coinsurance	10% Coinsurance
Emergency Room Services (Worldwide Coverage)	\$65 Copay	
Urgently Needed Care	\$35 Copay	
Inpatient Hospital or Long-Term Acute Care Facility Stay	5% Coinsurance	10% Coinsurance

¹ You must continue to pay your Medicare Part B premium.

HEALTH

Skilled Nursing Facility Care (100 days per Medicare benefit period)	5% Coinsurance	10% Coinsurance
Annual Routine Vision Exam (includes refraction)	\$0 copay	10% Coinsurance
Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. \$150 benefit maximum applies to non-standard frames and \$150 benefit maximum for specialty contact lenses.	\$150 benefit maximum
Annual Routine Hearing Exam	\$35 Copay	10% Coinsurance
Hearing Aids (In-network covered every year)	\$499 copay per aid per year for TruHearing Advanced \$799 copay per aid per year for TruHearing Premium. \$500 allowance for any other hearing aids through TruHearing every 3 years	\$500 allowance for hearing aids every 3 years.
Annual Routine Dental Care	Not Covered	Not Covered
Routine Podiatry Care (10 visits per calendar year)	Not covered	Not covered
Routine Chiropractic Office Visits (8 visits per year)	Not covered	Not covered
Home Health	5% Coinsurance	10% Coinsurance
Physical, Speech and Occupational Therapy (per visit/per day/per provider)	\$25 Copay	10% Coinsurance
Renal Dialysis	\$0 Copay	10% Coinsurance

¹ You must continue to pay your Medicare Part B premium.

Part B Drugs	5% Coinsurance	10% Coinsurance
Ambulance (Emergent Services per one way trip)	\$0 Copay	
Ambulance (Non-Emergent per one way trip)	\$0 Copay	10% Coinsurance
Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies)	5% Coinsurance	10% Coinsurance
Oxygen/Oxygen Supplies	5% Coinsurance	10% Coinsurance
Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	5% Coinsurance	10% Coinsurance
Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	\$35 Copay	10% Coinsurance

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PART D DRUGS - Not Covered

Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal.

Your health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Cross Blue Shield provides post-sale administrative communications for these companies.

Highmark Blue Cross Blue Shield and Highmark Senior Health Company all of which are independent licensees of the Blue Cross and Blue Shield Association.

You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Call the phone number on the back of your member ID card (TTY users may call 711) for more information. Out-of-network/non-contracted providers are under no obligation to treat Freedom Blue PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. TruHearing is a registered trademark of TruHearing, Inc.

Highmark Blue Cross Blue Shield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 seven days a week, from 8 a.m. to 8 p.m. (TTY users call 711).

Reference Code (Please have this number ready when you call): 21FB199715

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