2026 Benefit Summary

Employment Partners Benefits Fund

			178473	178474	884458	885977
			Freedom Blue PPO High Option	**Freedom Blue PPO Low Option**	**Community Blue Medicare PPO High Option**	**Community Blue Medicare PPO Low Option**
HEALTH		Per Person Per Month Premium	**$302**	**$159**	**$199**	**$144**
		Deductible	$0	$750	$0	$750
			In Network/Out of Network	**In Network/Out of Network**	**In Network/Out of Network**	**In Network/Out of Network**
		Coinsurance	0% / 0%	10% / 10%	10% / 20%	10% / 20%
		Out-of-Pocket Maximum	$3,400	$2,400 / $3,400	$2,000 / $3,400	$2,000 / $3,400
		Annual Physical Exam	Covered in Full	Covered in Full	Covered in Full	Covered in Full
		Screenings & Exams (Preventative PAP/Pelvic, Mammograms, Colorectal, Prostate & Bone Mass Measurement)	Covered in Full	Covered in Full	Covered in Full	Covered in Full
		Doctor Office Visit	$15 / $15	$25 / $25	$20 / 20%	$20 / 20%
		Specialist Office Visit	$30 / $30	$30 / $30	$25 / 20%	$25 / 20%
		X-ray or Radiology	0% / 0%	10% / 10%	10% / 20%	10% / 20%

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	Diagnostic Testing	0% / 0%	10% / 10%	10% / 20%	10% / 20%
	Outpatient Surgery	$25 / $25	10% / 10%	10% / 20%	10% / 20%
	Emergency Room Services (Worldwide Coverage)	$50	$50	$50	$50
	Urgently Needed Care (this is NOT emergency care)	$40	$40	$40	$40
	Inpatient Hospital Stay	$50 / $50 per stay	10% / 10% per stay	10%/20% per stay	10% / 20% per stay
	Skilled Nursing Facility Care (100 days per Medicare benefit period)	$0 / $0	$20 days 1-20 10% days 21-100/ $20 days 1-20 10% days 21-100	$20 days 1-20 10% days 21-100 /20%	$20 days 1-20 10% days 21-100 / 20%
	Annual Routine Vision Exam (Includes refraction)	$0 / $50 copay for eye exam	$0 / $50 copay for eye exam	$0 / $50 for eye exam	$0 / $50 for eye exam
	Eyeglasses or Contact Lenses (Covered every year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses. $150 benefit maximum	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses. $150 benefit maximum	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses. $150 benefit maximum	Standard eyeglass lenses and frames or contact lenses are covered in full. A $150 benefit maximum applies to non-standard frames and a $150 benefit maximum for specialty contact lenses. $150 benefit maximum

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	Annual Routine Hearing Exam	$30 / $30	$30 / $30	$25 / 20%	$25 / 20%
	Hearing Aids	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing	$499 copay per aid for TruHearing Advanced $799 copay per aid for TruHearing Premium $500 allowance for any other hearing aids through TruHearing
	Home Health	$0 / $0	10% / 10%	10% / 20%	10% / 20%
	Physical, Speech and Occupational Therapy (per visit/per day/per provider)	$30 / $30	$30 / $30	$25 / 20%	$25 / 20%
	Routine Podiatry Care Non-Medicare covered (10 visits per calendar year)	$30 / $30	$30 / $30	Coverage only for Medicare covered services only	Coverage only for Medicare covered services only
	Routine Chiropractic Office Visits Non Medicare covered (8 visits per year)	$20 / $30	$20 / $30	Coverage only for Medicare covered services only	Coverage only for Medicare covered services only

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		Annual Routine Dental Care	$20 copay for each office visit (oral exam and cleaning) up to one visit every six months $20 copay for dental x-rays up to one visit every six months. Full mouth x-rays every five years 50% coinsurance for restorative services 50% coinsurance for dentures every five years preventive denture maintenance every three years 50% coinsurance for endodontic services (limit 1 per tooth per lifetime). 50% coinsurance for crowns, inlays and onlays (limit 1 per tooth every 5 years).	$20 copay for each office visit (oral exam and cleaning) up to one visit every six months $20 copay for dental x-rays up to one visit every six months. Full mouth x-rays every five years 50% coinsurance for restorative services 50% coinsurance for dentures every five years preventive denture maintenance every three years 50% coinsurance for endodontic services (limit 1 per tooth per lifetime). 50% coinsurance for crowns, inlays and onlays (limit 1 per tooth every 5 years).	$20 copay for each office visit (oral exam and cleaning) up to one visit every six months $20 copay for dental x-rays up to one visit every six months. Full mouth x-rays every five years 50% coinsurance for restorative services 50% coinsurance for dentures every five years preventive denture maintenance every three years	$20 copay for each office visit (oral exam and cleaning) up to one visit every six months $20 copay for dental x-rays up to one visit every six months. Full mouth x-rays every five years 50% coinsurance for restorative services 50% coinsurance for dentures every five years preventive denture maintenance every three years

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	Part B Drugs	10% per quarter $300 per quarter member out of pocket maximum / 10% per quarter $300 per quarter member out of pocket maximum	10% / 10%	10% / 20%	10% / 20%
	Ambulance (Emergent Services per one way trip)	$75	10%	10%	10%
	Ambulance (Non-Emergent) Services per one way trip	$75 / 20%	10% / 20%	10% / 20%	10% / 20%
	Durable Medical Equipment (Prosthetics/Orthotics, Diabetic Testing Supplies, Oxygen/Oxygen Supplies)	15% / 20%	10% / 20%	10% / 20%	10% / 20%
	Inpatient Psychiatric Hospital Care (Limited to 190 days per lifetime)	$50 / $50 per stay	10% / 10% per stay	10% / 20% per stay	10% / 20% per stay

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		Outpatient Mental Health/Psychiatric Services or Chemical Dependency Substance Abuse Treatment (per individual or group session)	$30 / $30	$30 / $30	$25 / 20%	$25 / 20%

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MEDICARE PART D	PART D DRUGS UP TO 31 DAY RETAIL SUPPLY/ MAIL ORDER Up to 100 Day Supply - Tier 1 & 2 Up to 90 Day Supply- Tier 3 & 4	Initial Coverage Period	Preferred Pharmacy: $15 Tier 1 $15 Tier 2 $30 Tier 3 $60 Tier 4 33% Tier 5 Standard Pharmacy: $20 Tier 1 $20 Tier 2 $35 Tier 3 $65 Tier 4 33% Tier 5 Mail Order (Express Scripts): $37.50 Tier 1 $37.50 Tier 2 $75 Tier 3 $150 Tier 4 N/A Tier 5 Mail Order (All other mail order pharmacies) $50 Tier 1 $50 Tier 2 $87.50 Tier 3 $162.50 Tier 4 N/A Tier 5	Preferred Pharmacy: $15 Tier 1 $15 Tier 2 $40 Tier 3 $90 Tier 4 33% Tier 5 Standard Pharmacy: $20 Tier 1 $20 Tier 2 $45 Tier 3 $95 Tier 4 33% Tier 5 Mail Order: $37.50 Tier 1 $37.50 Tier 2 $100 Tier 3 $225 Tier 4 N/A Tier 5 Mail Order (All other mail order pharmacies) $50 Tier 1 $50 Tier 2 $112.50 Tier 3 $237.50 Tier 4 N/A Tier 5	Preferred Pharmacy: $15 Tier 1 $15 Tier 2 15% Tier 3 15%Tier 4 33% Tier 5 Standard Pharmacy: $20 Tier 1 $20 Tier 2 20%Tier 3 20%Tier 4 33% Tier 5 Mail Order: $37.50 Tier 1 $37.50 Tier 2 15% Tier 3 15% Tier 4 N/A Tier 5 Mail Order (All other mail order pharmacies) $50 Tier 1 $50 Tier 2 20% Tier 3 20% Tier 4 N/A Tier 5	Preferred Pharmacy: $15 Tier 1 $15 Tier 2 15% Tier 3 15% Tier 4 33% Tier 5 Standard Pharmacy: $20 Tier 1 $20 Tier 2 20% Tier 3 20% Tier 4 33% Tier 5 Mail Order: $37.50 Tier 1 $37.50 Tier 2 15% Tier 3 15% Tier 4 N/A Tier 5 Mail Order (All other mail order pharmacies) $50 Tier 1 $50 Tier 2 20% Tier 3 20% Tier 4 N/A Tier 5

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		Catastrophic Coverage Period	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	After reaching the True Out of Pocket (TrOOP) costs of $2,100, there is $0 member cost sharing for covered Part D drugs in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.

Questions on Freedom Blue PPO benefits? Call 1-866-456-7739 (TTY users call 711)
Reference Code (Please have this number ready when you call):

Freedom Blue PPO

26FB178473 – High Option

26FB178474 – Low Option

Community Blue PPO

26CB884458 – High Option

26CB885977 - Low Option

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

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Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

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All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

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