2024 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	**$283**	**$147**	**$192**	**$140**
		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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		Freedom Blue PPO High Option	Freedom Blue PPO Low Option	Community Blue Medicare PPO High Option	Community Blue Medicare PPO Low Option
	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 (up to $5,030 in total drug costs)	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 $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: $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 $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: $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

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		Coverage Gap Period (from $5,030.01 in total drug costs to $8,000 in yearly out-of-pocket drug costs)	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 $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: $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 $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: $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

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		Catastrophic Coverage Period (after $8,000.01 in total out-of-pocket drug costs)	There is $0 member cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	There is $0 member cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	There is $0 member cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.	There is $0 member cost sharing for covered Part D drugs for any beneficiaries in the catastrophic coverage phase, including for covered insulin products and Part D vaccinations.

- Diagnostic or outpatient surgery cost sharing may apply for non-screening preventive services.
- Physician office visit cost sharing may apply if a separately billable physician service is rendered.
- Certain categories of Medicare Part B drugs have been excluded from member cost sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain medications. Medicare Part B drugs are not available via retail pharmacy network.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. You must continue to pay your Medicare Part B premium. Highmark Senior Health Company is a PPO plan with a Medicare contract. Enrollment in Highmark Senior Health Company depends on contract renewal. Highmark is a registered mark of Highmark Inc. Highmark Senior Health Company is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association.

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

24FB178473 – High Option

24FB178474 – Low Option

Community Blue PPO

24CB884458 – High Option

24CB885977 - Low Option

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