

2026 Freedom Blue PPO (PA) Summary of Benefits

In-Network

Out-of-Network

Important Information

<p>Premium and Other Important Information</p>	<p>You may pay a premium each month to your retiree/employer group/trust fund. In addition, you keep paying your Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. For more information about Part B premiums based on income, visit www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	
<p>Plan Deductible</p>	<p>\$250</p>	
<p>Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)</p>	<p>\$1,000</p>	

Covered Medical and Hospital Benefits

<p>Notes:</p>	<p>Services with a 1 may require prior authorization.</p>	
<p>Inpatient Hospital Care¹ (includes Substance Abuse and Rehabilitation Services)</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>You pay: 0% coinsurance for each stay.</p>	<p>You pay: 0% coinsurance for each stay.</p>
<p>Outpatient Hospital/ Ambulatory Surgery Center¹</p>	<p>You pay: 0% coinsurance Outpatient Hospital You pay: 0% coinsurance Ambulatory Surgery Center</p>	<p>You pay: 0% coinsurance Outpatient Hospital You pay: 0% coinsurance Ambulatory Surgery Center</p>
<p>Doctor Office Visits</p> <p>Office visit copays do not apply to the annual deductible if applicable</p>	<p>You pay: \$20 copay Primary Care physician visit You pay: \$30 copay Specialist visit</p>	<p>You pay: \$20 copay Primary Care physician visit You pay: \$30 copay Specialist visit</p>
<p>Preventive Services</p>	<p>You pay: \$0 copay</p> <p>Our plan covers many preventive services, including: Abdominal Aortic Aneurysm screening, Alcohol misuse counseling, Bone Mass Measurement, Breast cancer screening (mammogram), Cardiovascular disease (behavioral therapy), Cardiovascular screenings, Cervical and Vaginal Cancer screening, Colorectal Cancer screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy), Depression screening, Diabetes screening, HIV screening, Medical nutrition therapy services, Obesity screening and counseling, Prostate cancer screenings (PSA), Sexually transmitted infections screening and counseling, Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease), Vaccine, including Flu shots, Hepatitis B shots, Pneumococcal shots, "Welcome to Medicare" preventive visit (one-time), Yearly "Wellness" visit</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p>	

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<p>Emergency Care You may go to any emergency room if you reasonably believe you need emergency care.</p>	<p>You pay: \$150 copay for each emergency room visit. Worldwide coverage for emergency and urgently needed care. If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.</p>	
<p>Urgent Care This is not emergency care</p>	<p>You pay: \$50 copay</p>	
<p>Diagnostic Tests, Lab, Radiology Services¹ Such as MRIs and CT Scans and X-rays</p>	<p>You pay: 0% coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 0% coinsurance for lab/diagnostic services in an outpatient facility. You pay: 0% coinsurance for standard imaging services You pay: 0% coinsurance for advanced imaging services. You pay: 0% coinsurance for therapeutic radiology services.</p>	<p>You pay: 0% coinsurance for lab/diagnostic services in a physicians office or independent lab. You pay: 0% coinsurance for lab/diagnostic services in an outpatient facility. You pay: 0% coinsurance for standard imaging services You pay: 0% coinsurance for advanced imaging services. You pay: 0% coinsurance for therapeutic radiology services.</p>
<p>Hearing Services Medicare covered exam to diagnose and treat hearing and balance issues</p>	<p>You pay: \$30 copay</p>	<p>You pay: \$30 copay</p>
<p>Hearing Services Routine exam up to 1 every year. Cost sharing is not applied to the Combined In and Out-of-Network Out-of-Pocket Maximum.</p>	<p>You pay: \$30 copay \$499 per aid per year for TruHearing Advanced \$799 per aid per year for TruHearing Premium.</p>	<p>You pay: \$30 copay \$500 allowance for hearing aids every 3 years from any other provider.</p>
<p>Dental Services¹ Preventive dental services (such as cleaning) not covered Authorization rules may apply for Medicare-covered accidental dental services.</p>	<p>Medicare covered dental benefits you pay: \$30 copay.</p>	<p>Medicare covered dental benefits you pay: \$30 copay.</p>
<p>Vision Medicare covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p>	<p>You pay: \$30 copay \$200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.</p>	<p>You pay: \$30 copay \$200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.</p>
<p>Mental Health Care¹ Inpatient visit: Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Office visit copays do not apply to the annual deductible.</p>	<p>Inpatient stay you pay: 0% coinsurance Outpatient individual/group therapy visit for other mental health care services you pay: \$30 copay Outpatient individual therapy visit with a psychiatrist you pay: \$30 copay</p>	<p>Inpatient stay you pay: 0% coinsurance Outpatient individual/group therapy visit for other mental health care services you pay: \$30 copay Outpatient individual therapy visit with a psychiatrist you pay: \$30 copay</p>

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Skilled Nursing Facility (SNF)¹ Medicare-certified skilled nursing facility	You pay: 0% coinsurance per admission for days 1-100. No prior hospital stay is required.	You pay: 0% coinsurance per admission for days 1-100. No prior hospital stay is required.
Physical Therapy¹	You pay: \$30 copay for Medicare-covered Physical Therapy visits.	You pay: \$30 copay for Medicare-covered Physical Therapy visits.
Ambulance Services¹ Medically necessary ambulance services	You pay: \$100 copay	Emergency - You pay: \$100 copay Non-Emergency - You pay: 10% coinsurance
Transportation (Routine)¹ Combined 24 one way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	You pay: \$10 copay per trip.	You pay: 50% coinsurance for out-of-network transportation services.
Part B Drugs¹ Drugs covered under Medicare Part B. See Section 1 for more Information on Medicare Part B Drugs. Part B covers Immunosuppressive drugs, Oral chemotherapy drugs, Physician administered injectables, Nebulizer drugs and other Part B drugs.	You pay: 0% coinsurance	You pay: 0% coinsurance
Acupuncture¹ Medicare-covered Acupuncture visits up to 12 visits in 90 days for chronic low back pain.	You pay: \$30 copay for Medicare-covered Acupuncture visits.	You pay: \$30 copay for Medicare-covered Acupuncture visits.
Chiropractic Care¹ Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part)	You pay: \$20 copay	You pay: \$20 copay
Diabetes Supplies and Services¹ includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes.	You pay: 0% coinsurance Diabetes self-management training you pay: \$0. If the doctor provides you additional services, separate doctor office visit cost sharing may apply.	You pay: 10% coinsurance
Durable Medical Equipment¹ Includes wheelchairs, prosthetics, oxygen, etc.	You pay: 0% coinsurance for durable medical equipment. You pay: 0% coinsurance for oxygen and oxygen supplies.	You pay: 10% coinsurance for durable medical equipment. You pay: 10% coinsurance for oxygen and oxygen supplies.
Foot Care (podiatry services) Medicare covered exam -Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	You pay: \$30 copay	You pay: \$30 copay
Home Health Care¹	You pay: 0% coinsurance	You pay: 0% coinsurance

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Outpatient Rehabilitation¹ Cardiac Rehabilitation Occupational Therapy, Physical Therapy, Speech and Language Therapy	<p>You pay: \$0 copay for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>	<p>You pay: \$0 copay for Cardiac (heart) Rehabilitation services.</p> <p>You pay: \$30 copay for Medicare-covered Occupational, Physical, Speech and Language Therapy visits.</p>
Over the Counter Drug Allowance	<p>Not Covered</p>	
Renal Dialysis Services To Treat Kidney Disease	<p>You pay: \$0 copay</p>	<p>You pay: 10% coinsurance</p>
Wellness/Education and Other Supplemental Benefits & Services	<p>The plan covers the following supplemental education/wellness programs: Nationwide Fitness Network Membership/Fitness Classes</p>	<p>You pay: 50% of the cost for out-of-network health/wellness services after a \$500 deductible.</p>
Hospice	<p>You pay: \$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.</p>	

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Part D Prescription Drug Benefits

You pay the following until you reach the True Out of Pocket (TrOOP) costs threshold of \$2,100.
Deductible - \$0

You may have cost sharing for drugs that are covered under Medicare Excluded Part D

Formulary Type Incentive

DRUG

Initial Coverage	Network Retail Pharmacy	Tier	31 Day Supply	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4
		Tier 1 (Preferred Generic Drugs)	\$12 copay	\$36 copay
	Tier 2 (Generic Drugs)	\$12 copay	\$36 copay	
	Tier 3 (Preferred Brand Drugs and Generics)	\$35 copay	\$105 copay	
	Tier 4 (Non-Preferred Drugs)	\$65 copay	\$195 copay	
	Tier 5 (Specialty drugs consist of both Generic and Brand)	\$65 copay	Not Available	
Initial Coverage	Mail Order	Tier	Up to 100 Day Supply Tier 1 & 2 Up to 90 Day Supply Tier 3 & 4	
		Tier 1 (Preferred Generic Drugs)	\$24 copay	
		Tier 2 (Generic Drugs)	\$24 copay	
		Tier 3 (Preferred Brand Drugs and Generics)	\$40 copay	
		Tier 4 (Non-Preferred Drugs)	\$100 copay	
		Tier 5 (Specialty drugs consist of both Generic and Brand)	\$65 copay for a 31 day limit supply	

Catastrophic Coverage After reaching the True Out of Pocket (TrOOP) costs, 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.
You may have cost sharing for drugs that are covered under Medicare Excluded Part D drug rider.

Important Message If you have prescription cost sharing more than \$35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is \$35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).

For questions about this plan's benefits or costs, please contact Freedom Blue PPO (PA). Call 1-866-456-7739, (TTY users call 711), Monday through Friday, between 8 a.m. and 4:30 p.m. ET. Please have Reference Code 26FB0178428 ready when you call.



Important Information about Certain Medicare Excluded Prescription Drugs

The following is a list of Medicare Part D excluded drugs covered under your plan. The cost sharing for these drugs is Generic-Tier 2 and Brand-Tier 4 listed in your plan documents.

Drug Name	Requirements/Limits
Caverject Vial (ea) 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Caverject Kit 10 mcg and 20 mcg	QL (0.2 EA per 1 day), *, +
Cialis Tablet 2.5 mg	QL (2 EA per 1 day), *, +
Cialis Tablet 5 mg	QL (1 EA per 1 day), *, +
Cialis Tablet 10 mg and 20 mg	QL (0.2 EA per 1 day), *, +
Drisdol 1.25 MG (50,000 Unit)	*, +
Edex Kit 10 mcg, 20 mcg and 40 mcg	QL (0.2 EA per 1 day), *, +
Ergocal Ciferol 1.25 mg	*, +
Folic Acid Tablet 1 mg	*, +
IFE-BIMIX 30/1 150-5 MG/5 ML	QL (0.2 EA per 1 day), *, +
IFE-PG20 100 MCG/5 ML VIAL	QL (0.2 EA per 1 day), *, +
Levitra Tablet 2.5 mg, 5 mg, 10 mg and 20 mg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 125 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 250 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 500 mcg	QL (0.2 EA per 1 day), *, +
Muse Suppository, Urethral 1000 mcg	QL (0.2 EA per 1 day), *, +
PAPAVRN 30 MG-PHENTO 1 MG/ML	QL (0.2 EA per 1 day), *, +
PPVRN 12MG-PHNT 1MG-ALPR 10MCG	QL (0.2 EA per 1 day), *, +
PPVRN 30MG-PHNT 1MG-ALPR 20MCG	QL (0.2 EA per 1 day), *, +
Promethazine HCL/Codeine Syrup 6.25-10/5	*, +
Promethazine DM Syrup 6.25-15/5	*, +
Sildenafil 25 MG, 50MG and 100 MG TABLET	QL (0.2 EA per 1 day), *, +
Staxyn Tablet, Disintegrating 10 mg	QL (0.2 EA per 1 day), *, +
Stendra Tablet 50 mg, 100 mg and 200 mg	*, +
Tadalafil 2.5 MG TABLET	QL (2 EA per 1 day), *, +
Tadalafil 5 MG TABLET	QL (1 EA per 1 day), *, +
Tadalafil 10 MG and 20 MG TABLET	QL (0.2 EA per 1 day), *, +
TRI-MIX 150 MG-5 MG-50 MCG VL	QL (0.2 EA per 1 day), *, +
Viagra Tablet 25 mg, 50 mg and 100 mg	QL (0.2 EA per 1 day), *, +
Vitamin D2 1.25MG(50,000 UNIT)	*, +
Vitamin D2 50 MCG (2,000 UNIT)	*, +

+ - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

You can find information on what the symbols and abbreviations on this table mean by going to page 10 of the formulary.