Medicare Advantage
2026 Benefit Summary

Name: The Steelworkers H & W Fund -0198879

	Freedom Blue PPO (PA) PPO	
Medical Benefits	**In-Network**	**Out-of-Network**
Deductible	$250	
Coinsurance (see specific benefits for cost sharing)	10%	10%
In-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$1,500	Not Applicable
Combined In and Out-of-Network Member Out-of-Pocket Maximum Amount (This is the most the member will pay out-of-pocket for their Medicare-covered services, not including Part D drugs)	$3,400	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$20	$20
Office Visits - Specialist	$35	$35
Radiation Therapy	0%	10%
Emergency Room (waived if admitted within 3 days)	$65	
Urgent Care	$40	
Ambulance (Emergent)	10%	
Ambulance (Non-Emergent)	10%	30%
Routine Transportation Combined 24 one-way trips. Transportation related to continued acute care after discharge does not apply towards the trip limit.	$10	50%
More than 20 Preventive Services	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	10%	10%
Observation Room/Outpatient Surgery (Hospital)	10%	10%
Outpatient Surgery (Ambulatory Center)	10%	10%
Home Health Care	10%	10%
Skilled Nursing Facility (100 days per benefit period)	$20 per day 1-20/ 10% per day 21-100	$20 per day 1-20/ 10% per day 21-100
Dialysis	$0	30%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	10%	10%
Mental Health (Outpatient)	$35	$35
Mental Health (Outpatient with Psychiatrist)	$35	$35
Alcohol Substance Abuse (Inpatient)	10%	10%
Alcohol Substance Abuse (Outpatient)	$35	$35

Laboratory and X-ray Services	In-Network	Out-of-Network
Laboratory Testing (Physician Office/Free Standing Lab)	10%	10%
Laboratory Testing (Outpatient Facility)	10%	10%
X-rays	10%	10%
Advanced Radiology (MRI, MRA, PET, and CT)	10%	10%
Rehabilitation Services	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$35	$35
Chiropractor Medicare Covered	$20	$35
Cardiac Rehab	$0	10%
Vision	**In-Network**	**Out-of-Network**
Medical Vision Exam	$35	$35
Routine Vision Exam (Offered through Davis Vision)	$0	$50
Annual allowance (lenses and frames) Offered through Davis Vision	$0 for Davis Vision Fashion Collection frames and standard lenses or $150 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses	$150 benefit maximum
Hearing	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$35	$35
Routine Hearing Exam (TruHearing)	$35	$35
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid.	$500 allowance for hearing aids every 3 years
Dental	**In-Network**	**Out-of-Network**
Routine Dental	Not Covered	Not Covered
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**
Durable Medical Equipment	10%	20%
Prosthetics	10%	20%
Oxygen	10%	20%
Diabetic Supplies (Part B)	10%	10%
Fitness Program	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Covered	

Part B Drugs	In-Network	Out-of-Network
Immunosuppressive Drugs	10%	10%
Oral Chemotherapy Drugs	10%	10%
Physician Administered Injectables	10%	10%
Nebulizer Inhalation	10%	10%
Part B drugs (other)	10%	10%
Prescription Drugs - Part D		
Prescription Deductible	Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	$2,100	
Formulary	Incentive	
Medicare Excluded Part D Prescription Drug Rider	Not Covered	
Retail Prescription Drugs	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$10	$15
Tier 2 (Non-Preferred Generic)	$10	$15
Tier 3 (Preferred Brand & Generic)	$25	$30
Tier 4 (Non-Preferred)	$55	$60
Tier 5 (Specialty)	33%	33%
Mail Order Prescription Drugs	**Express Scripts**	**All other Mail Order Pharmacies**
Tier 1 (Preferred Generic)	$25	$37.50
Tier 2 (Non-Preferred Generic)	$25	$37.50
Tier 3 (Preferred Brand & Generic)	$62.50	$75
Tier 4 (Non-Preferred)	$137.50	$150
Tier 5 (Specialty)	33%	33%
Retail and Mail Order Days Supply Limit	- Retail or Mail Order -Tier 1 & 2 - Up to a 100 day supply - Retail or Mail Order - Tier 3 & 4 - Up to a 90 day supply - Specialty Drugs are limited to a 31-day supply -Insulin - $35 maximum copay for a one-month supply of covered insulin products	
Catastrophic Phase	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.	

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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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For questions about this plan's benefits or costs, please call 1-866-456-7739 (TTY 711), Monday -Friday 8 am - 4:30 pm.
Please have this number ready when you call 26FB0198879

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