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HIGHMARK. WESTERN NEW YORK

Suggested Plan: Forever Blue 799 (PPO) Plan 11

	Cost
Monthly premium effective January 1, 2024	$517.00

	Current		Upon renewal	
Physician and other health professional services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary doctor/Specialist	$5/$15	$20/$20	$5/$15	$20/$20
Radiation therapy	$15	$20	$15	$20
Emergency room (waived if admitted)	$50	$50	$50	$50
Urgent care (waived if admitted)	$50	$50	$50	$50
Ambulance	$25	$25	$25	$25
More than 20 preventive services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Flu shots - Part B	Covered in full	Covered in full	Covered in full	Covered in full
Immunizations - Part B (hepatitis/pneumonia)	Covered in full	$20	Covered in full	$20
All other preventive screenings and tests	Covered in full	$20	Covered in full	$20
Hospital, home health care, and skilled services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital (inpatient)	$100 / 1 copay max per year	20%	$100 / 1 copay max per year	20%
Outpatient surgery - hospital	$35	$50	$35	$50
Outpatient surgery - ambulatory center	$35	$50	$35	$50
Home health care	Covered in full	$10	Covered in full	$10
Skilled nursing facility	$100 / 1 copay max per year	20%	$20 a day 1-5 / $100 max per year	20%
Dialysis	Covered in full	Inside service area: 20% for non-participating providers. Outside service area: $0 for non-participating providers.	Covered in full	Inside service area: 20% for non-participating providers. Outside service area: $0 for non-participating providers.
Mental health/chemical dependence services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental health (inpatient, 190-day lifetime limit)	$100 / 1 copay max per year	20%	$100 / 1 copay max per year	20%
Mental health (outpatient)	$40	30%	$40	30%
Mental health (with psychiatrist)	$20	30%	$20	30%
Alcohol substance abuse (inpatient)	$100 / 1 copay max per year	20%	$100 / 1 copay max per year	20%
Alcohol substance abuse (outpatient)	20%	30%	20%	30%
Laboratory and X-ray services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory testing	Covered in full	$20	Covered in full	$20
X-rays	$15	$20	$15	$20
Advanced radiology - MRI, MRA, PET, and CT	$15	$20	$15	$20

Rehabilitation services	In-Network	Out-of-Network	In-Network	Out-of-Network
Physical, occupational, and speech therapy	$15	$20	$15	$20
Acupuncture & Massage Therapy	$500 annual allowance		$500 annual allowance	
Chiropractor	$15 includes 12 routine visits	$20 includes 12 routine visits	$15 includes 12 routine visits	$20 includes 12 routine visits
Cardiac rehab	$15	$20	$15	$20

Vision	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine vision exam	$15	20%	$15	20%
Allowance (lenses and frames)	$300 annual allowance		$300 annual allowance	

Hearing	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine hearing exam - TruHearing™	$45	$45	$45	$45
Hearing aid benefit - TruHearing™	$499 / $799		$499 / $799	

Dental	In-Network	Out-of-Network	In-Network	Out-of-Network
Dental allowance	$300 annual allowance		$300 annual allowance	

Supplies, equipment and devices	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable medical equipment	$0 compression stockings; 20% all other items	30%	$0 compression stockings; 20% all other items	30%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	30%	$0 diabetic shoes/inserts; 20% all other items	30%
Diabetic supplies - Part B	Covered in full	30%	Covered in full	30%

Fitness program	In-Network	Out-of-Network	In-Network	Out-of-Network
SilverSneakers® ("Steps" program included)	Covered in full		Covered in full	

Prescription drugs - Part B	In-Network	Out-of-Network	In-Network	Out-of-Network
Immunosuppressive drugs	Covered in full	Covered in full	Covered in full	Covered in full
Oral chemotherapy drugs	Covered in full	Covered in full	Covered in full	Covered in full
Physician administered injectables	Covered in full	Covered in full	Covered in full	Covered in full
Nebulizer inhalation solution	Covered in full	Covered in full	Covered in full	Covered in full
Part B drugs - other	Covered in full	Covered in full	Covered in full	Covered in full

Prescription drugs - Part D	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription drug (Rx)	$0/$10/$20/$40/$40		$0/$10/$20/$40/$40	
Mail order (90-day supply)	Tier 1 - Tier 4 2 copays for a 90 day supply		2 copays for: Tiers 1-2 100-day supply Tiers 3-4 90-day supply	
Coverage gap/donut hole	No coverage gap		No coverage gap	

General product information	In-Network	Out-of-Network	In-Network	Out-of-Network
In-network out-of-pocket maximum	$3,000	N/A	$3,000	N/A
Combined out-of-pocket maximum	$3,000		$3,000	
RX deductible	N/A		N/A	