Plan: Blue Saver

Monthly premium effective January 1, 2025	2024 Benefits	2025 Benefits
Medical Benefits	**In-Network**	**In-Network**
Deductible	$0	$0
Coinsurance (see specific benefits for cost sharing)	0%	0%
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)	$6,900	$6,900
Physician and other Health Professional Services	**In-Network**	**In-Network**
Office Visits - Primary Doctor	$0	$0
Office Visits - Specialist	$30	$30
Radiation Therapy	20%	20%
Emergency Room (waived if admitted within 1 day)	$110	$110
Urgent Care	$45	$45
Ambulance	$270	$270
More than 20 Preventive Services	**In-Network**	**In-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**	**In-Network**
Hospital (Inpatient)	$350 per day for days 1-6, $2,100 OOP Max per year	$350 per day for days 1-6, $2,100 OOP Max per year
Observation Room/Outpatient Surgery (Hospital)	$375	$375
Outpatient Surgery (Ambulatory Center)	$275	$275
Home Health Care	$0	$0
Skilled Nursing Facility (100 days per benefit period)	$0 per day for days 1-20; $214.00 per day for days 21-100. No yearly benefit period maximum.	$0 per day for days 1-20; $214.00 per day for days 21-100. No yearly benefit period maximum.
Dialysis	$0	$0
Mental Health/Chemical Dependence Services	**In-Network**	**In-Network**
Mental Health (Inpatient, 190-day lifetime limit)	$395 per day for days 1-4, $1,580 OOP Max per year	$395 per day for days 1-4, $1,580 OOP Max per year
Mental Health (Outpatient)	$40	$40
Mental Health (Outpatient with Psychiatrist)	$40	$40
Alcohol Substance Abuse (Inpatient)	$395 per day for days 1-4, $1,580 OOP Max per year	$395 per day for days 1-4, $1,580 OOP Max per year
Alcohol Substance Abuse (Outpatient)	$40	$40
Laboratory and X-ray Services	**In-Network**	**In-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$0 Lab Copay IN; $50 Diagnostic test IN	$0 Lab Copay IN; $50 Diagnostic test IN
Laboratory Testing (Outpatient Facility)	$0 Lab Copay IN; $50 Diagnostic test IN	$0 Lab Copay IN; $50 Diagnostic test IN
X-rays	$45	$45
Advanced Radiology (MRI, MRA, PET, and CT)	$175	$175
Rehabilitation Services	**In-Network**	**In-Network**
Physical, Occupational, and Speech Therapy	$30	$30
Chiropractor Medicare Covered	$15	$15
Acupuncture & Massage Therapy Annual Allowance	$250	Not Covered
Cardiac Rehab	$10	$10
Vision	**In-Network**	**In-Network**
Medical Vision Exam	$30	$30
Routine Vision Exam (Offered through Davis Vision)	$25	$25
Annual allowance (lenses and frames) Offered through Davis Vision	$100	$100
Hearing	**In-Network**	**In-Network**
Diagnostic Hearing Exam	$30	$30
Routine Hearing Exam (TruHearing)	$45	$45
Hearing Aid Benefit (TruHearing)	2 Hearing Aids Every year; TruHearing Advanced - $699 copay; TruHearing Premium - $999 copay	2 Hearing Aids Every year; TruHearing Advanced - $699 copay; TruHearing Premium - $999 copay
Dental	**In-Network**	**In-Network**
Routine Dental Allowance	$2,000	$2,000
Supplies, Equipment, and Devices	**In-Network**	**In-Network**
Durable Medical Equipment	$0 compression stockings; 20% all other items	$0 compression stockings; 20% all other items
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	$0 diabetic shoes/inserts; 20% all other items
Oxygen	20%	20%

Diabetic Supplies (Part B)	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin		20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin	
Fitness Program	**In-Network**		**In-Network**	
Highmark Fitness Program	Silver Sneakers		National Fitness Network	
Part B Drugs	**In-Network**		**In-Network**	
Immunosuppressive Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN		0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN	
Oral Chemotherapy Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN		0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN	
Physician Administered Injectables	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN		0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN	
Nebulizer Inhalation	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN		0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN	
Part B drugs (other)	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN		0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance for all other Part B drugs IN	
Value Added Rider	**In-Network**		**In-Network**	
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 12 per calendar year.	$15 Copay IN (6 per plan year)		$15 Copay IN (6 per plan year)	
Routine Podiatry - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 3 visits per calendar year.	$30 Copay IN (3 visits)		$30 Copay IN (3 visits)	
Meal Plan - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered		Covered	
Prescription Drugs - Part D				
Prescription Deductible	Tier 1 - Tier 3: $0, Tier 4 - Tier 5: $250		Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	$2,000		$2,000	
Formulary	Fundamental		Fundamental	
Retail Prescription Drugs	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$0	$5	$0	$5
Tier 2 (Non-Preferred Generic)	$2	$17	$2	$17
Tier 3 (Preferred Brand & Generic)	25%	25%	25%	25%
Tier 4 (Non-Preferred)	50%	50%	50%	50%
Tier 5 (Specialty)	33%	33%	33%	33%
Mail Order Prescription Drugs	**Express Scripts**	**All other Mail Order Pharmacies**	**Express Scripts**	**All other Mail Order Pharmacies**
Tier 1 (Preferred Generic)	$0	$12.50	$0	$12.50
Tier 2 (Non-Preferred Generic)	$0	$42.50	$10	$42.50
Tier 3 (Preferred Brand & Generic)	25%	25%	$30	25%
Tier 4 (Non-Preferred)	50%	50%	$60	50%
Tier 5 (Specialty)	33%	33%	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		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 Out of Pocket costs of $8,000, 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, 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.	

Total Premium Per Member, Per Month	$0	$0

Please return to your Senior Markets Client Manager.

Signature auto renewed - no signature required Date

Printed Name Title

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