Plan: Senior Blue 651

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)	$6,700	$6,700
Physician and other Health Professional Services	**In-Network**	**In-Network**
Office Visits - Primary Doctor	$0	$0
Office Visits - Specialist	$25	$25
Radiation Therapy	20%	20%
Emergency Room (waived if admitted within 1 day)	$125	$125
Urgent Care	$55	$55
Ambulance	$200	$200
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)	$225 per day for days 1-7, $1,575 OOP Max per year	$225 per day for days 1-7, $1,575 OOP Max per year
Observation Room/Outpatient Surgery (Hospital)	$325	$325
Outpatient Surgery (Ambulatory Center)	$225	$225
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)	$215 per day for days 1-6, $1,290 OOP Max per year	$215 per day for days 1-6, $1,290 OOP Max per year
Mental Health (Outpatient)	$40	$40
Mental Health (Outpatient with Psychiatrist)	$40	$40
Alcohol Substance Abuse (Inpatient)	$215 per day for days 1-6, $1,290 OOP Max per year	$215 per day for days 1-6, $1,290 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)	$5 Lab Copay IN; $40 Diagnostic test IN	$5 Lab Copay IN; $40 Diagnostic test IN
Laboratory Testing (Outpatient Facility)	$5 Lab Copay IN; $40 Diagnostic test IN	$5 Lab Copay IN; $40 Diagnostic test IN
X-rays	$40	$40
Advanced Radiology (MRI, MRA, PET, and CT)	$150	$150
Rehabilitation Services	**In-Network**	**In-Network**
Physical, Occupational, and Speech Therapy	$15	$15
Chiropractor Medicare Covered	$15	$15
Acupuncture & Massage Therapy Annual Allowance	$500	Not Covered
Cardiac Rehab	$15	$15
Vision	**In-Network**	**In-Network**
Medical Vision Exam	$25	$25
Routine Vision Exam (Offered through Davis Vision)	$25	$25
Annual allowance (lenses and frames) Offered through Davis Vision	$200	$200
Hearing	**In-Network**	**In-Network**
Diagnostic Hearing Exam	$25	$25
Routine Hearing Exam (TruHearing)	$45	$45
Hearing Aid Benefit (TruHearing)	2 Hearing Aids Every year; TruHearing Advanced - $499 copay; TruHearing Premium - $799 copay	2 Hearing Aids Every year; TruHearing Advanced - $499 copay; TruHearing Premium - $799 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 (12 per plan year)		$15 Copay IN (12 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.	$25 Copay IN (3 visits)		$25 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	Not Applicable		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)	$2	$7	$0	$7
Tier 2 (Non-Preferred Generic)	$10	$15	$10	$15
Tier 3 (Preferred Brand & Generic)	$42	$47	$42	$47
Tier 4 (Non-Preferred)	$94	$100	$94	$100
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	$17.50	$0	$17.50
Tier 2 (Non-Preferred Generic)	$25	$37.50	$25	$37.50
Tier 3 (Preferred Brand & Generic)	$105	$117.50	$105	$117.50
Tier 4 (Non-Preferred)	$235	$250	$235	$250
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	$115	$101

Please return to your Senior Markets Client Manager.

Signature auto renewed - no signature required Date

Printed Name Title

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be
provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:
Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.
Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.
All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue
companies.
The Blue Shield(c) and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.
TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express
Scripts® is a separate company. Other Pharmacies/Physicians/Providers are available in our network.
Out-of-network/non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more
information, including the cost-sharing that applies to out-of-network services.
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.
我们免费提供口译服务，为您解答有关我们健康计划或药物 计划的任何疑问。如需口译服务，只需拨打您所在州相应的 电话号码即可。说中文的工作人员可为您提供帮助。此项服务免 费。

EGHP_24_3669_M