Plan: Forever Blue 751

Monthly premium effective January 1, 2025	2024 Benefits		2025 Benefits	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$0		$0	
Coinsurance (see specific benefits for cost sharing)	0%	25%	0%	25%
In-Network Member Out-of-Pocket Maximum Amount	$6,700	N/A	$6,700	N/A
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)	$10,000		$10,000	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$0-$5 Copay IN	20%	$0-$5 Copay IN	20%
Office Visits - Specialist	$25	25%	$25	25%
Radiation Therapy	20%	25%	20%	25%
Emergency Room (waived if admitted within 1 day)	$125		$125	
Urgent Care	$55		$55	
Ambulance	$225		$225	
More than 20 Preventive Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital (Inpatient)	$205 per day for days 1-7, $1,435 OOP Max per year IN	30%	$205 per day for days 1-7, $1,435 OOP Max per year IN	30%
Observation Room/Outpatient Surgery (Hospital)	$300	25%	$300	25%
Outpatient Surgery (Ambulatory Center)	$200	25%	$200	25%
Home Health Care	$0	25%	$0	25%
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 IN	30%	$0 per day for days 1-20; $214.00 per day for days 21-100. No yearly benefit period maximum IN	30%
Dialysis	$0 Copay IN	50%	$0 Copay IN	50%
Mental Health/Chemical Dependence Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health (Inpatient, 190-day lifetime limit)	$270 per day for days 1-6, $1,620 OOP Max per year IN	30%	$270 per day for days 1-6, $1,620 OOP Max per year IN	30%
Mental Health (Outpatient)	$40	50%	$40	50%
Mental Health (Outpatient with Psychiatrist)	$40	50%	$40	50%
Alcohol Substance Abuse (Inpatient)	$270 per day for days 1-6, $1,620 OOP Max per year IN	30%	$270 per day for days 1-6, $1,620 OOP Max per year IN	30%
Alcohol Substance Abuse (Outpatient)	$40	50%	$40	50%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$5 Lab Copay IN; $40 Diagnostic Tests	25%	$5 Lab Copay IN; $40 Diagnostic Tests	25%
Laboratory Testing (Outpatient Facility)	$5 Lab Copay IN; $40 Diagnostic Tests	25%	$5 Lab Copay IN; $40 Diagnostic Tests	25%
X-rays	$40	25%	$40	25%
Advanced Radiology (MRI, MRA, PET, and CT)	$150	25%	$150	25%
Rehabilitation Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$20	25%	$20	25%
Chiropractor Medicare Covered	$15	25%	$15	25%
Acupuncture & Massage Therapy Annual Allowance	$500		Not Covered	
Cardiac Rehab	$15	25%	$15	25%
Vision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Vision Exam	$25	25%	$25	25%
Routine Vision Exam (Offered through Davis Vision)	$25 Copay IN	20%	$25 Copay IN	20%
Annual allowance (lenses and frames) Offered	$200		$200	

Hearing	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Hearing Exam	$25	25%	$25	25%
Routine Hearing Exam (TruHearing)	$45 Copay (1 Every Year)	Not Applicable	$45 Copay (1 Every Year)	Not Applicable
Hearing Aid Benefit (TruHearing)	2 Hearing Aids Every year; TruHearing Advanced - $499 copay; TruHearing Premium - $799 copay	Not Applicable	2 Hearing Aids Every year; TruHearing Advanced - $499 copay; TruHearing Premium - $799 copay	Not Applicable
Dental	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Dental Allowance	$2,000		$2,000	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment	$0 compression stockings; 20% all other items	50%	$0 compression stockings; 20% all other items	50%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	50%	$0 diabetic shoes/inserts; 20% all other items	50%
Oxygen	20%	50%	20%	50%
Diabetic Supplies (Part B)	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN	$35	20% Coinsurance up to a maximum of a $35 copay for a one month supply of insulin IN	$35
Fitness Program	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Highmark Fitness Program	Silversneakers		National Fitness Network	
Part B Drugs	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Immunosuppressive Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%
Oral Chemotherapy Drugs	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%
Physician Administered Injectables	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%
Nebulizer Inhalation	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%
Part B drugs (other)	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%	0%-19.99% Coinsurance for Part B rebatable drugs and 20% Coinsurance IN; 25% Coinsurance OON	25%
Value Added Rider	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Chiropratic - These are routine/not medically	$15 Copay IN	25%	$15 Copay IN	25%
Routine Podiatry - These are routine/not medically	$25 Copay IN	$15	$25 Copay IN	$15
Meal Plan - 1 meal per day up to 7 days after discharge	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Prescription Drugs - Part D				
Prescription Deductible	Not Applicable		Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	Not Applicable		$2,000	
Formulary	Fundamental		Fundamental	
Retail Prescription Drugs (for up to a 31 day supply)	**Preferred**	**Standard**	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$2	$7	$0	$7
Tier 2 (Non-Preferred Generic)	$8	$13	$8	$13
Tier 3 (Preferred Brand & Generic)	$42	$47	$42	$47
Tier 4 (Non-Preferred)	$94	$99	$94	$99
Tier 5 (Specialty)	33%	33%	33%	33%
Mail Order Prescription Drugs	**Express Scripts**	**All other Mail Order**	**Express Scripts**	**All other Mail**
Tier 1 (Preferred Generic)	$0	$17.50	$0	$17.50
Tier 2 (Non-Preferred Generic)	$20	$32.50	$20	$32.50
Tier 3 (Preferred Brand & Generic)	$105	$117.50	$105	$117.50
Tier 4 (Non-Preferred)	$235	$247.50	$235	$247.50
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	$209	$197

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