Plan: Forever Blue 799 (PPO) Plan 11

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%	0%	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)	$3,000	Not Applicable	$3,000	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)	$3,000		$3,000	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$5	$20	$5	$20
Office Visits - Specialist	$15	$20	$15	$20
Radiation Therapy	$15	$20	$15	$20
Emergency Room (waived if admitted within 1 day)	$50		$50	
Urgent Care	$50		$50	
Ambulance	$25		$25	
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)	$100 / 1 copay max per year	20%	$100 / 1 copay max per year	20%
Observation Room/Outpatient Surgery (Hospital)	$35	$50	$35	$50
Outpatient Surgery (Ambulatory Center)	$35	$50	$35	$50
Home Health Care	0%	$10	0%	$10
Skilled Nursing Facility (100 days per benefit period)	$20 per day 1-5/ $0 per day 6-100 ($100 max a year)	20% per day 1-100	$20 per day 1-5/ $0 per day 6-100 ($100 max a year)	20% per day 1-100
Dialysis	$0	Inside service area: 20% for non-participating providers. Outside service area: $0 for non-participating providers.	$0	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 (Outpatient 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%	$40	30%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$0	$20	$0	$20
Laboratory Testing (Outpatient Facility)	$0	$20	$0	$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
Chiropractor Medicare Covered	$15	$20	$15	$20
Acupuncture & Massage Therapy Annual Allowance	$500		$500	
Cardiac Rehab	$15	$20	$15	$20
Vision	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Vision Exam	$15	$20	$15	$20
Routine Vision Exam (Offered through Davis Vision)	$15	20%	$15	20%

Annual allowance (lenses and frames) Offered through Davis Vision	$300		$300	
Hearing	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$15	$20	$15	$20
Routine Hearing Exam (TruHearing)	$45	$45	$45	$45
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid.	Not Applicable	TruHearing: You pay a $499 copay for the Advanced or a $799 copay for the Premium hearing aid.	Not Applicable
Dental	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Dental Allowance	$300		$300	
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%
Oxygen	20%	30%	20%	30%
Diabetic Supplies (Part B)	0%	30%	0%	30%
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%	0%	0%	0%
Oral Chemotherapy Drugs	0%	0%	0%	0%
Physician Administered Injectables	0%	0%	0%	0%
Nebulizer Inhalation	0%	0%	0%	0%
Part B drugs (other)	0%	0%	0%	0%
Value Added Rider	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-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	$20	$15	$20
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.	$15	$20	$15	$20
Meal Plan - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	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				
Tier 1 (Preferred Generic)	$0		$0	
Tier 2 (Non-Preferred Generic)	$10		$10	
Tier 3 (Preferred Brand & Generic)	$20		$20	
Tier 4 (Non-Preferred)	$40		$40	
Tier 5 (Specialty)	$40		$40	
Mail Order Prescription Drugs				
Tier 1 (Preferred Generic)	$0		$0	
Tier 2 (Non-Preferred Generic)	$20		$20	
Tier 3 (Preferred Brand & Generic)	$40		$40	
Tier 4 (Non-Preferred)	$80		$80	
Tier 5 (Specialty)	$40		$40	
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	$517	$551

Please return to your Senior Markets Client Manager.

Signature auto renewed - no signature required Date

Printed Name Title

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