HIGHMARK

Western New York

Forever Blue 751 (PPO)

Summary of Benefits

January 1, 2024 to December 31, 2024

To enroll in the following plan(s), you need to be entitled to Medicare Part A, enrolled in Medicare Part B, and live in one of these counties:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

This summary of benefits doesn't list every service, limitation, or special circumstance.
Visit us at **medicare.highmark.com** to get more benefit information including:

- **Evidence of Coverage** *(full list of benefits)*
- **Provider and Pharmacy Directories**
- **Formulary** *(full Part D prescription drug list)*

If you need printed copies, call us at **1-800-329-2792** (TTY 711). We're available October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Forever Blue 751 (PPO) has a network of pharmacies. The out-of-network (OON) benefit provides "out-of-network" coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than you would if you used a "network provider."

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	Forever Blue 751 (PPO)
Premium	$209.00
Part B Premium Reduction	$0.00
Deductible	$0
Max Out-Of-Pocket	$6,700 IN; $10,000 combined IN and OON
Inpatient Hospital Stay	Days 1 - 7: $205 copay per day per admit & Days 8 - 90: $0 copay per admit IN* with a $1,435 OOP Max per year; 30% coinsurance per admit OON
Outpatient Hospital Coverage	ASC[1]: $200 copay IN*; 25% coinsurance OON Facility: $300 copay IN*; 25% coinsurance OON
Doctor Office Visit	PCP: $5 copay IN; 25% coinsurance OON Specialist: $25 copay IN; 25% coinsurance OON
Preventive/Screening	Covered in Full (Office visit copays may apply) IN; 25% coinsurance OON
Emergency Room	$100 copay IN/OON
Urgently Needed Services	$55 copay IN/OON
Lab & Diagnostic Tests	Office Lab: $5 copay IN*; 25% coinsurance OON; Outpatient Lab: $5 copay IN*; 25% coinsurance OON Diagnostic Tests: $40 copay IN; 25% coinsurance OON
X-Rays/ Advanced Imaging	X-ray: $40 copay IN*; 25% coinsurance OON Advanced Imaging: $150 copay IN*; 25% coinsurance OON
Hearing Services	Medicare Covered: $25 copay IN; 25% coinsurance OON. Routine: $45 copay IN; $45 copay OON (1 Per Year). TruHearing Advanced: $499 copay; TruHearing Premium: $799 copay. (2 Aids Every Year IN/OON)
Dental Services	Medicare Covered: $25 copay IN; 25% coinsurance OON. Office Visit: $0 copay IN; 0% coinsurance OON (2 per year). X-Rays: $0 copay IN; 0% coinsurance OON (1 per year). Comprehensive*: 50% coinsurance IN; 50% coinsurance OON; with a maximum $2,000 allowance IN/OON (Per Year)
Vision Services	Medicare Covered: $25 copay IN; 25% coinsurance OON. Routine: $25 copay IN; 20% coinsurance OON (1 Per Year). $0 copay IN; 20% OON coinsurance for eyeglasses or contact lenses after cataract surgery. $200 annual eyewear allowance IN/OON.
Mental Health Services	Inpatient: Days 1 - 6: $270 copay per day per admit & Days 7 - 90: $0 copay per day per admit IN*; $1,620 OOP Max per year for IN; 30% coinsurance per day per admit OON; Outpatient: $40 copay IN; 50% coinsurance OON
Skilled Nursing Facility	$0 copay/day (days 1-20), $203 copay/day (days 21-100) IN*; 30% coinsurance OON
Physical Therapy	$20 copay IN; 25% coinsurance OON
Ambulance (per one-way trip)	$225 copay IN*/OON
Transportation	Not covered
Part B Drugs[†]	20% coinsurance IN*; 25% coinsurance OON
OTC	$35 allowance once per quarter IN/OON
Durable Medical Equipment	20% coinsurance IN*; 50% coinsurance OON $0 copay for compression stockings (IN only)
Fitness Benefit	SilverSneakers covered in full IN; 50% coinsurance after satisfying a $500 deductible OON
Formulary	Fundamental

*Indicates a service that requires prior authorization.

ASC[1]=Ambulatory Surgery Center

†Certain rebatable drugs may be subject to a lower coinsurance. Insulin cost sharing is subject to a coinsurance cap of $35 for a one-month's supply of insulin.

Forever Blue 751 (PPO)

DRUG

You pay the following until your total yearly drug costs reach $5,030.
Total yearly drug costs are the total drug costs paid by both you and your Part D plan.

Deductible: $0

Initial Coverage

Preferred Retail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$2 Copay	$6 Copay
Tier 2 (Generic)	$8 Copay	$24 Copay
Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$94 Copay	$282 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Retail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$7 Copay	$21 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$99 Copay	$297 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Preferred Mail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$2 Copay	$0 Copay
Tier 2 (Generic)	$8 Copay	$20 Copay
Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
Tier 3 (Preferred Brand)	$42 Copay	$105 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$94 Copay	$235 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Standard Mail Cost-Sharing

Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)
Tier 1 (Preferred Generic)	$7 Copay	$17.50 Copay
Tier 2 (Generic)	$13 Copay	$32.50 Copay
Tier 3 (Preferred Insulin)	$35 Copay	$105 Copay
Tier 3 (Preferred Brand)	$47 Copay	$117.50 Copay
Tier 4 (Insulin)	$35 Copay	$105 Copay
Tier 4 (Non-Preferred Drug)	$99 Copay	$247.50 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Applicable

Coverage Gap: The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Generics (25% Coinsurance) Brand (25% Coinsurance including 70% discount)

Catastrophic Coverage: After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.

Highmark Blue Cross 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.

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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.

Out-of-network/non-contracted providers are under no obligation to treat Forever Blue 751 (PPO) members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

This information is not a complete description of benefits. Call 1-844-537-7720 (TTY users may call 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week; April 1 – September 30, 8 a.m. to 8 p.m., Monday – Friday for more information.

TruHearing is a registered trademark of TruHearing, Inc.

SilverSneakers is a registered trademark of Tivity Health, Inc. Tivity Health, Inc., is a separate company that administers the SilverSneakers program.