

## **Northeastern New York**

Forever Blue 770 (PPO)

## **Summary of Benefits**

January 1, 2026 to December 31, 2026

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:

Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington

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 7 days a week, 8 a.m. to 8 p.m.

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 770 (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."

Premium S0 Part B Premium S0 Reduction Deductible S0 Max Out-Of-Pocket Inpatient Hospital Stay S1,435 OOP Max per year for IN Outpatient Hospital Coverage Facility: \$275 copay Ner; 25% coinsurance OON Freventive/Screening Coverage Facility: \$275 copay Ner; 25% coinsurance OON Preventive/Screening Coverage Facility: \$275 copay Ner; 25% coinsurance OON Specialist: \$22 copay Ner; 25% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Freestanding Lab: \$5 copay INP; 55 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, 55 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, 55 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Advanced Imaging: \$150 copay IN*, 25% coinsurance OON Hearing Services Medicare Covered: \$22 copay IN*, 25% coinsurance OON Reductare Covered: \$22 copay IN*, 25% coinsurance OON Routine Services Medicare Covered: \$22 copay IN*, 25% coinsurance OON Routine X-rays: \$0 copay IN*, 50 copay OON (1 per year). Routine X-rays: \$0 copay IN*, 50 copay OON (2 per year). Routine X-rays: \$0 copay IN*, 50 copay OON (2 per year). Routine X-rays: \$0 copay IN*, 50 copay OON (1 per year). Routine X-rays: \$0 copay IN*, 50 copay OON (5 per year). Routine: \$25 copay IN*, 25% coinsurance OON. Medicare Covered: \$22 copay IN*, 25% coinsurance OON. Socionsurance OON Routine: \$25 copay IN*, 50 copay OON (6 per year). Routine: \$25 copay IN*, 50 copay OON (7 per year). Routine: \$25 copay IN*, 50 copay OON (7 per year). Routine: \$25 copay IN*, 50 copay OON (7 per year). So copay IN*, 20% coinsurance OON Combined. Inpatient: Days: 1 - 6: \$270 copay per day per admit IN*, 50 copay per day per admit IN*, 51,620 OOP Max Persorices Skilled Nursing Facility Script Script Script Script Script Script Script Script						
Part B Premium Reduction Deductible \$0  Max Out-Of-Pocket Inpatient Hospital Days 1 - 7: \$205 copay per day per admit & Days 8 - 90: \$0 copay per admit IN*, 30% coinsurance per admit OON \$1,435 OOP Max per year for IN Outpatient Hospital Coverage Facility: \$275 copay IN*; 25% coinsurance OON Freventive/Screening Doctor Office Visit PCP: \$0.55 copay IN*; 25% coinsurance OON Specialist: \$22 copay IN*; 25% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered Screening Covered Covered Screening Covered Sc		Forever Blue 770 (PPO)				
Reduction						
Max Out-Of-Pocket Inpatient Hospital Days 1 - 7: \$205 copay per day per admit & Days 8 - 90: \$0 copay per admit IN*; 30% coinsurance per admit OON \$1,435 COP Max per year for IN Outpatient Hospital Coverage ASC': \$175 copay IN*; 25% coinsurance OON Doctor Office Visit Poch Soc Sopay IN; 25% coinsurance OON Specialist: \$22 copay IN; 25% coinsurance OON Specialist: \$22 copay IN; 25% coinsurance OON Specialist: \$23 copay IN; 25% coinsurance OON Specialist: \$23 copay IN; 25% coinsurance OON Overed in Full (Office visit copays may apply) IN; 30% coinsurance OON Urgently Needed Services Lab & Diagnostic Tests Freestanding Lab: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Advanced Imaging: \$150 copay IN*, 25% coinsurance OON Medicare Covered: \$22 copay IN*, 50 copay OON (1 per year). Comprehensive: 50% coinsurance IN*, 50% coinsurance OON Medicare Covered: \$22 copay IN*, 50 copay OON (1 per year). Comprehensive: 50% coinsurance IN*, 50% coinsurance OON Medicare Covered: \$22 copay IN*, 50 copay OON (1 per year). So copay IN*, 20% OON coinsurance OON (1 per year). So copay IN*, 20% OON coinsurance OON (1 per year). So copay IN*, 20% Coinsurance OON (1 per year). So copay IN*, 20% Coinsurance OON (1 per year). So copay IN*, 20% Coinsurance OON (1 per year). So copay IN*, 20% Coinsurance OON (1 per year). So copay IN	Part B Premium Reduction	\$0				
Inpatient Hospital Stay  Days 1 - 7: \$205 copay per day per admit & Days 8 - 90: \$0 copay per admit IN*; 30% coinsurance per admit OON \$1,455 OOP Max per year for IN  Outpatient Hospital Coverage  Poctor Office Visit PCP: \$0.55 copay IN*; 25% coinsurance OON Facility: \$275 copay IN*; 25% coinsurance OON Specialist: \$22 copay IN, 25% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Incently Needed Services Lab & Diagnostic Freestanding Lab: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON A:Rays/ Advanced Medicare Covered: \$22 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, \$25% coinsurance OON Medicare Covered: \$22 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, \$45 copay OON (I Per Year), TruHearing Advanced Imaging: \$150 copay IN*, \$25% coinsurance OON Medicare Covered: \$22 copay IN*, 25% coinsurance OON Medicare Covered: \$22 copay IN*, 25% coinsurance OON, Routine: \$45 copay IN*, \$45 copay OON (I Per Year), TruHearing Advanced: \$499 copay (2 Aids Every Year IN/OON)  Dental Services  Medicare Covered: \$22 copay IN*, 25% coinsurance OON, Routine: \$45 copay IN*, 25% coinsurance OON, Routine: \$4	Deductible	\$0				
Slay Slay Slay Slay Slay ODM Max per year for IN Outpatient Hospital Coverage Facility: \$275 copay IN*; 25% coinsurance OON Coverage Facility: \$275 copay IN*; 25% coinsurance OON Doctor Office Visit PCP: \$0.55 copay IN; 25% coinsurance OON Specialist: \$22 copay IN; 25% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Preventive/Screening Emergency Room Urgently Needed Services Lab & Diagnostic Tests Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Tests Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Advanced Imaging Hearing Services Medicare Covered: \$22 copay IN; 25% coinsurance OON Advanced Imaging: \$150 copay IN*; 25% coinsurance OON Medicare Covered: \$22 copay IN; 25% coinsurance OON Routine Office Visit: \$0 copay IN; \$0 copay OON; Diagnostic Tests: \$40 copay IN*, \$45 copay OON (1 Per Year). TruHearing Advanced: \$499 copay (2 Aids Every Year IN/OON); TruHearing Premium: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; \$25% coinsurance OON. Routine Office Visit: \$0 copay IN; \$0 copay OON (1 per year). Routine Office Visit: \$0 copay IN; \$0 copay OON (2 per year). Routine Office Visit: \$0 copay IN; \$0 copay OON (1 per year). Comprehensive: \$0 copay IN; \$0 copay OON (1 per year). Comprehensive: \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$0 copay IN; \$0 copay OON (1 per year). So copay IN; \$0 copay IN; \$	Max Out-Of-Pocket	\$6,700 IN; \$10,000 combined IN and OON				
Coverage Facility: \$27\$ copay IN*; 25% coinsurance OON PCP: So-S5 copay IN; 25% coinsurance OON Specialist: \$22 copay IN; 25% coinsurance OON Preventive/Screening Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON Interpetive/Screening Emergency Room Urgently Needed Services Lab & Diagnostic Freestanding Lab: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Tests Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Tests Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Advanced Imaging: \$150 copay IN*; 25% coinsurance OON Imaging Hearing Services Medicare Covered: \$22 copay IN; 25% coinsurance OON Hedicare Covered: \$22 copay IN; 25% coinsurance OON Routine Covered: \$22 copay IN; 25% coinsurance OON Routine Office Visit: \$0 copay IN*; 25% coinsurance OON Routine Office Visit: \$0 copay IN; \$0 copay OON (1 per year). Routine Office Visit: \$0 copay IN; \$0 copay OON (2 per year). Routine Trays: \$0 copay IN; \$0 copay OON (1 per year). Comprehensive: \$0% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (comprehensive) IN/OON (Per Year). See the EOC for full benefits.  Vision Services Medicare Covered: \$22 copay IN; 25% coinsurance OON: \$0 diabetic retinal eye exam IN. Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). So copay IN; 20% OON coinsurance OON (1 Per Year). So copay IN; 20% OON coinsurance of consurance OON: \$0 diabetic retinal eye exam IN. Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). Services Services Services So copay IN; 20% coinsurance per day per admit to Days 7 - 90: \$0 copay per day per admit IN*; \$1,620 OOP Max per year for IN; 30% coinsurance per day per admit to Days 7 - 90: \$0 copay per day per admit IN*; \$1,620 OOP Max per year for IN; 30% coinsurance per day per admit to Days 7 - 90: \$0 copay IN; 50% coinsurance OON Stilled Nursing Facility First Servic	Inpatient Hospital Stay					
Preventive/Screening Preventiv	Outpatient Hospital Coverage					
Urgently Needed S50 copay IN/OON Services Lab & Diagnostic Tests Freestanding Lab: \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON X-Rays/ Advanced Imaging Advanced Imaging: \$150 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Medicare Covered: \$120 copay IN*, 25% coinsurance OON Medicare Covered: \$22 copay IN; 25% coinsurance OON Nedicare Covered: \$22 copay IN; 25% coinsurance OON, TruHearing Premium: \$799 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$22 copay IN; 25% coinsurance OON, TruHearing Premium: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; 25% coinsurance OON, Routine: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; 25% coinsurance OON, Routine: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; 25% coinsurance OON, Routine: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; 25% coinsurance OON, Routine: \$799 copay. (2 Aids Every Year IN/OON) Medicare Covered: \$22 copay IN; 25% coinsurance OON, So diabetic retinal eye exam IN. Routine: \$25 copay IN; 25% coinsurance OON, So diabetic retinal eye exam IN. Routine: \$25 copay IN; 25% coinsurance OON (1 Per Year). So copay IN; 20% OON coinsurance for eyeglasses or contact lenses after cataract surgery. \$200 annual eyewear allowance IN/OON Combined.  Mental Health Services  Mental Health Inpatient: Days 1 - 6: \$270 copay per day per admit & Days 7 - 90: \$0 copay per day per admit IN*; \$1,620 OOP Max Services  Pry sall for Inpatient: Days 1 - 6: \$270 copay per day per admit & Days 7 - 90: \$0 copay IN; 50% coinsurance OON  Skilled Nursing Facility Physical Therapy  Ambulance (per one- way trip) Transportation  Not Covered  20% coinsurance IN*; 25% coinsurance OON  Sulled Medicare  S40 allowance once per quarter IN/OON  Durable Medical  20% coinsurance IN*; 50% coinsurance OON  S0 copay for compression st	Doctor Office Visit					
Urgently Needed Services Lab & Diagnostic Freestanding Lab: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON X-Rays/ Advanced Imaging X-Rays/ Advanced Imaging Medicare Covered: \$22 copay IN*, 25% coinsurance OON Advanced: \$40 copay IN*, 25% coinsurance OON Hearing Services Medicare Covered: \$22 copay IN; 25% coinsurance OON. Routine: \$45 copay IN; \$45 copay OON (1 Per Year). TruHearing Advanced: \$499 copay (2 Aids Every Year IN/OON); TruHearing Premium: \$799 copay. (2 Aids Every Year IN/OON) Dental Services Medicare Covered: \$22 copay IN; 25% coinsurance OON. Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year). Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year). Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year). Comprehensive: \$0% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (comprehensive) IN/OON (Per Year). See the EOC for full benefits.  Wedicare Covered: \$22 copay IN; 25% coinsurance OON (1 Per Year). So copay IN; 20% colon coinsurance OON (1 Per Year). So copay IN; 20% coinsurance OON (1 Per Year). So copay IN; 20% coinsurance OON (1 Per Year). So copay IN; 20% coinsurance IN/OON Combined. Inpatient: Days 1 - 6: \$270 copay per day per admit IN*; \$1,620 OOP Max per year for IN; 30% coinsurance 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 Physical Therapy  \$15 copay IN*, 25% coinsurance OON  Medicare Part B Drugs¹  Not Covered  Medicare Part B Drugs¹  20% coinsurance IN*; 55% coinsurance OON  S40 allowance once per quarter IN/OON  Durable Medical Equipment  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Preventive/Screening	Covered in Full (Office visit copays may apply) IN; 30% coinsurance OON				
Services  Lab & Diagnostic Tests  Diffice/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON  X-Rays/ Advanced Imaging  Hearing Services  Medicare Covered: \$22 copay IN, 25% coinsurance OON, Routine: \$45 copay IN*, 25% coinsurance OON  Noutine Office Visit: \$0 copay IN*, 25% coinsurance OON, Routine: \$45 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine Office Visit: \$0 copay IN, 25% coinsurance OON, Routine S25 copay IN, 20% coinsurance OON (1 Per Year). See the EOC for full benefits.  Wision Services  Medicare Covered: \$22 copay IN, 25% coinsurance OON (1 Per Year). See the EOC for full benefits.  Wision Services  Medicare Covered: \$22 copay IN, 25% coinsurance OON (1 Per Year). See the EOC for full benefits.  Mental Health  Services  Inpatient: Days I - 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 & Days 7 - 90: \$0 copay per day per admit IN*, \$1,620 OOP Max per year for IN; 30% coinsurance 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 & Days 7 - 90: \$0 copay per day Per admit IN*, \$1,620 OOP Max per year for IN; 30% coinsurance per day per admit & Days 7 - 90: \$0 copay Per day Per Admit & Days 7 - 90: \$0 copay Per Admit & Days 7 - 90: \$0 copay Per Admit & Days 7 - 90: \$	Emergency Room	\$130 copay IN/OON				
Tests Office/Outpatient: \$5 copay IN*, \$5 copay OON; Diagnostic Tests: \$40 copay IN*, 25% coinsurance OON X-Rays/ Advanced	Urgently Needed Services	\$50 copay IN/OON				
Imaging	Lab & Diagnostic Tests					
Advanced: \$499 copay (2 Aids Every Year IN/OON); TruHearing Premium: \$799 copay. (2 Aids Every Year IN/OON)  Dental Services  Medicare Covered: \$22 copay IN; 25% coinsurance OON, Routine Office Visit: \$0 copay IN; \$0 copay OON (2 per year), Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year), Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (comprehensive) IN/OON (Per Year). See the EOC for full benefits.  Vision Services  Medicare Covered: \$22 copay IN; 25% coinsurance OON, \$0 diabetic retinal eye exam IN. Routine: \$25 copay IN; 20% COON coinsurance OON (1 Per Year). \$0 copay IN; 20% OON 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 Combined.  Mental Health  Inpatient: Days 1 - 6: \$270 copay per day per admit & Days 7 - 90: \$0 copay 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  Physical Therapy  \$15 copay IN*; 25% coinsurance OON  Ambulance (per one-way trip)  Transportation  Not Covered  Medicare Part B  Drugs*  OTC  \$40 allowance once per quarter IN/OON  Durable Medical Equipment  Advance S499 copay IN; 25% coinsurance OON  S0 copay for compression stockings, diabetic shoes/inserts (IN only)	X-Rays/ Advanced Imaging					
Routine Office Visit: \$0 copay IN; \$0 copay OON (2 per year). Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year). Comprehensive: 50% coinsurance IN; 50% coinsurance OON; with a maximum \$2,000 allowance (comprehensive) IN/OON (Per Year). See the EOC for full benefits.  Wedicare Covered: \$22 copay IN; 25% coinsurance OON, \$0 diabetic retinal eye exam IN. 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 Combined.  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  Physical Therapy  \$15 copay IN*; 25% coinsurance OON  Ambulance (per one- way trip)  Not Covered  Medicare Part B Drugs¹  OTC  \$40 allowance once per quarter IN/OON  Durable Medical Equipment  Routine \$200 coinsurance IN*; 50% coinsurance OON  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Hearing Services					
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 Combined.  Mental Health Inpatient: Days 1 - 6: \$270 copay per day per admit & Days 7 - 90: \$0 copay per day per admit IN*; \$1,620 OOP Max Services  Skilled Nursing Facility  \$0 copay/day (days 1 - 20), \$218 copay/day (days 21 - 100) IN*; 30% coinsurance OON  \$15 copay IN*; 25% coinsurance OON  Ambulance (per one- way trip)  Transportation  Not Covered  Medicare Part B Drugs¹  OTC  \$40 allowance once per quarter IN/OON  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Dental Services	Routine Office Visit: \$0 copay IN; \$0 copay OON (2 per year).  Routine X-rays: \$0 copay IN; \$0 copay OON (1 per year).  Comprehensive: 50% coinsurance IN; 50% coinsurance OON;				
Services per year for IN; 30% coinsurance per day per admit OON; Outpatient: \$40 copay IN; 50% coinsurance OON  Skilled Nursing Facility Physical Therapy \$15 copay IN*; 25% coinsurance OON  Ambulance (per oneway trip)  Transportation Not Covered  Medicare Part B Drugs†  OTC \$40 allowance once per quarter IN/OON  Durable Medical Equipment  per year for IN; 30% coinsurance Part By coinsurance OON  \$15 copay IN*; 25% coinsurance OON  Not Covered  20% coinsurance IN*; 25% coinsurance OON  20% coinsurance IN*; 50% coinsurance OON  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Vision Services	Routine: \$25 copay IN; 20% coinsurance OON (1 Per Year). \$0 copay IN; 20% OON coinsurance for eyeglasses or contact lenses after cataract surgery.				
Facility  Physical Therapy \$15 copay IN*; 25% coinsurance OON  Ambulance (per oneway trip)  Transportation  Medicare Part B  Drugs†  OTC \$40 allowance once per quarter IN/OON  Durable Medical Equipment  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Mental Health Services					
Ambulance (per one-way trip)  Transportation  Not Covered  Medicare Part B Drugs†  OTC  \$40 allowance once per quarter IN/OON  Durable Medical Equipment  \$315 copay IN*/OON  Not Covered  20% coinsurance OON  20% coinsurance IN*; 25% coinsurance OON  \$40 allowance once per quarter IN/OON  20% coinsurance IN*; 50% coinsurance OON  \$40 copay for compression stockings, diabetic shoes/inserts (IN only)	Skilled Nursing Facility	\$0 copay/day (days 1 - 20), \$218 copay/day (days 21 - 100) IN*; 30% coinsurance OON				
way trip)  Transportation  Not Covered  Medicare Part B  Drugs†  OTC  \$40 allowance once per quarter IN/OON  Durable Medical Equipment  \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Physical Therapy	\$15 copay IN*; 25% coinsurance OON				
Medicare Part B Drugs†  OTC \$40 allowance once per quarter IN/OON  Durable Medical 20% coinsurance IN*; 50% coinsurance OON  Equipment \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Ambulance (per one- way trip)	\$315 copay IN*/OON				
Drugs <sup>†</sup> OTC \$40 allowance once per quarter IN/OON  Durable Medical 20% coinsurance IN*; 50% coinsurance OON  Equipment \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Transportation	Not Covered				
Durable Medical Equipment  20% coinsurance IN*; 50% coinsurance OON \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	Medicare Part B Drugs <sup>†</sup>	20% coinsurance IN*; 25% coinsurance OON				
Equipment \$0 copay for compression stockings, diabetic shoes/inserts (IN only)	OTC	\$40 allowance once per quarter IN/OON				
	Durable Medical	20% coinsurance IN*; 50% coinsurance OON				
Formulary Fundamental	Equipment	\$0 copay for compression stockings, diabetic shoes/inserts (IN only)				
	Formulary	Fundamental				

ASC¹=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.

<sup>\*</sup>Indicates a service that requires prior authorization.

Deductible	Tier 1-Tier 2:	\$0, Tier 3-5: \$615			
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4)	
Initial	Preferred	Tier 1 (Preferred Generic)	\$0 Copay	\$0 Copay	
	Retail	Tier 2 (Generic)	\$3 Copay	\$9 Copay	
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay	
	Sharing	Tier 3 (Preferred Brand)	20% of the cost	20% of the cost	
		Tier 4 (Insulin)	\$35 Copay	\$105 Copay	
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost	
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4	
	Standard	Tier 1 (Preferred Generic)	\$7 Copay	\$21 Copay	
	Retail	Tier 2 (Generic)	\$15 Copay	\$45 Copay	
	Cost-	Tier 3 (Preferred Insulin)	\$35 Copay	\$105 Copay	
	Sharing	Tier 3 (Preferred Brand)	20% of the cost	20% of the cost	
		Tier 4 (Insulin)	\$35 Copay	\$105 Copay	
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost	
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	
Coverage		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4	
S N	Preferred	Tier 1 (Preferred Generic)	Not Applicable	\$0 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$7 Copay	
	Cost-	Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay	
	Sharing	Tier 3 (Preferred Brand)	Not Applicable	20% of the cost	
		Tier 4 (Insulin)	Not Applicable	\$105 Copay	
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost	
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	
		Tier	31 Day Supply	100 Day (T1/2) 90 Day (T3/4	
	Standard	Tier 1 (Preferred Generic)	Not Applicable	\$17.50 Copay	
	Mail	Tier 2 (Generic)	Not Applicable	\$37.50 Copay	
	Cost-	Tier 3 (Preferred Insulin)	Not Applicable	\$105 Copay	
	Sharing	Tier 3 (Preferred Brand)	Not Applicable	20% of the cost	
		Tier 4 (Insulin)	Not Applicable	\$105 Copay	
		Tier 4 (Non-Preferred Drug)	Not Applicable	25% of the cost	
		Tier 5 (Specialty Tier)	25% of the cost	Not Applicable	
Catastrophic Coverage	After your yeareaches \$2,10	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches \$2,100, the plan pays the full cost for your covered Part D drugs. You pay nothing.			



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.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. The Blue Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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 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.

This information is not a complete description of benefits. Call 1-866-746-7971 (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. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.