Medicare Advantage
2025 Northeastern New York Benefit Summary

Effective Date: 1/1/2025
Name: CASHIC - Schalmont CSD Medicare
Group Number: 10728345

Plan: Forever Blue 799 (PPO) Plan CF12 TRx	**Forever Blue 799 (PPO)**	
Medical Benefits	**In-Network**	**Out-of-Network**
Deductible	$0	
Coinsurance (see specific benefits for cost sharing)	0%	20%
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)	$1,250	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)	$1,250	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$15	20%
Office Visits - Specialist	$15	20%
Radiation Therapy	$20	$20
Emergency Room (waived if admitted within 1 day)	$50	
Urgent Care	$25	
Ambulance	$50	
More than 20 Preventive Services	**In-Network**	**Out-of-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**	**Out-of-Network**
Hospital (Inpatient)	0%	20%
Observation Room/Outpatient Surgery (Hospital)	$15	20%
Outpatient Surgery (Ambulatory Center)	$15	20%
Home Health Care	0%	10%
Skilled Nursing Facility (100 days per benefit period)	0% per day 1-100	20% per day 1-100
Dialysis	$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**
Mental Health (Inpatient, 190-day lifetime limit)	0%	20%
Mental Health (Outpatient)	$15	20%
Mental Health (Outpatient with Psychiatrist)	$15	20%
Alcohol Substance Abuse (Inpatient)	0%	20%
Alcohol Substance Abuse (Outpatient)	$15	20%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$0	20%
Laboratory Testing (Outpatient Facility)	$0	20%
X-rays	$0	20%
Advanced Radiology (MRI, MRA, PET, and CT)	$0	20%
Rehabilitation Services	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$15	20%
Chiropractor Medicare Covered	$15	20%
Acupuncture & Massage Therapy Annual Allowance	$500	
Cardiac Rehab	$15	20%
Vision	**In-Network**	**Out-of-Network**
Medical Vision Exam	$15	20%
Routine Vision Exam (Offered through Davis Vision)	$15	20%

Annual allowance (lenses and frames) Offered through Davis Vision	$200	
Hearing	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$15	15%
Routine Hearing Exam (TruHearing)	$45	$45
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $699 copay for the Advanced or a $999 copay for the Premium hearing aid.	Not Applicable
Dental	**In-Network**	**Out-of-Network**
Routine Dental Allowance	$200	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**
Durable Medical Equipment	$0 compression stockings; 0% all other items	50%
Prosthetics	$0 diabetic shoes/inserts; 0% all other items	50%
Oxygen	0%	50%
Diabetic Supplies (Part B)	0%	20%
Fitness Program	**In-Network**	**Out-of-Network**
Highmark Fitness Program	National Fitness Network	
Part B Drugs	**In-Network**	**Out-of-Network**
Immunosuppressive Drugs	0%	0%
Oral Chemotherapy Drugs	0%	0%
Physician Administered Injectables	0%	0%
Nebulizer Inhalation	0%	0%
Part B drugs (other)	0%	0%
Value Added Rider	**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%
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%
Meal Plan - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered in Full	Not Applicable
Prescription Drugs - Part D		
Prescription Deductible	Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	$2,000	
Formulary	Fundamental	

Retail Prescription Drugs (for up to a 31 day supply)	**Preferred**	**Standard**
Tier 1 (Preferred Generic)	$0	$5
Tier 2 (Non-Preferred Generic)	$5	$10
Tier 3 (Preferred Brand & Generic)	$10	$15
Tier 4 (Non-Preferred)	$25	$30
Tier 5 (Specialty)	$25	$30
Mail Order Prescription Drugs	**Express Scripts**	**All other Mail Order Pharmacies**
Tier 1 (Preferred Generic)	$0	$10
Tier 2 (Non-Preferred Generic)	$10	$20
Tier 3 (Preferred Brand & Generic)	$20	$30
Tier 4 (Non-Preferred)	$50	$60
Tier 5 (Specialty)	$25	$30

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
Catastrophic Phase	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.

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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)
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For questions about this plan's benefits or costs, please call 1-855-215-9239 (TTY 711), Monday -Friday 8 am - 5 pm.
Reference Code (Please have this number ready when you call): 25FB0CF12