



**Medicare Advantage
2025 Western New York Benefit Summary**

Effective Date: 1/1/2025

Name: City of Lockport Medicare

Group Number: 10720345

Plan: Forever Blue 799 (PPO) Plan 11

	Forever Blue 799 (PPO)	
Medical Benefits	In-Network	Out-of-Network
Deductible	\$0	
Coinsurance (see specific benefits for cost sharing)	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
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	
Physician and other Health Professional Services	In-Network	Out-of-Network
Office Visits - Primary Doctor	\$5	\$20
Office Visits - Specialist	\$15	\$20
Radiation Therapy	\$15	\$20
Emergency Room (waived if admitted within 1 day)	\$50	
Urgent Care	\$50	
Ambulance	\$25	
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)	\$100 / 1 copay max per year	20%
Observation Room/Outpatient Surgery (Hospital)	\$35	\$50
Outpatient Surgery (Ambulatory Center)	\$35	\$50
Home Health Care	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
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)	\$100 / 1 copay max per year	20%
Mental Health (Outpatient)	\$40	30%
Mental Health (Outpatient with Psychiatrist)	\$20	30%
Alcohol Substance Abuse (Inpatient)	\$100 / 1 copay max per year	20%
Alcohol Substance Abuse (Outpatient)	\$40	30%
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	\$15	\$20
Advanced Radiology (MRI, MRA, PET, and CT)	\$15	\$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	\$0
Annual allowance (lenses and frames) Offered through Davis Vision	\$300	
Hearing	In-Network	Out-of-Network
Diagnostic Hearing Exam	\$15	\$20
Routine Hearing Exam (TruHearing)	\$45	20%
Hearing Aid Benefit (TruHearing)	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
Routine Dental Allowance	\$300	
Supplies, Equipment, and Devices	In-Network	Out-of-Network
Durable Medical Equipment	\$0 compression stockings; 20% all other items	30%
Prosthetics	\$0 diabetic shoes/inserts; 20% all other items	30%
Oxygen	20%	30%
Diabetic Supplies (Part B)	0%	30%
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		
Tier 1 (Preferred Generic)	\$0	
Tier 2 (Non-Preferred Generic)	\$10	
Tier 3 (Preferred Brand & Generic)	\$20	
Tier 4 (Non-Preferred)	\$40	
Tier 5 (Specialty)	\$40	
Mail Order Prescription Drugs		
Tier 1 (Preferred Generic)	\$0	
Tier 2 (Non-Preferred Generic)	\$20	
Tier 3 (Preferred Brand & Generic)	\$40	
Tier 4 (Non-Preferred)	\$80	
Tier 5 (Specialty)	\$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
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.

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. Benefits and/or benefit administration

may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

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.

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TruHearing is a registered trademark of TruHearing, Inc., a separate company. Davis Vision is an independent company that provides the network and administers vision benefits for Highmark members. Express

Scripts® is a separate company. Other Pharmacies/Physicians/Providers are available in our network.

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.

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)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos.

Para obtener un intérprete, simplemente llame al número

correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

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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): 25FB011

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