



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

**Effective Date: 1/1/2025**

**Name: Greater Capital Association of Realtors Inc., Medicare**

**Group Number: 10728005**

**Plan: Forever Blue 799 (PPO) Plan SF3 TRx**

	<b>Forever Blue 799 (PPO)</b>	
<b>Medical Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Deductible	\$0	
Coinsurance (see specific benefits for cost sharing)	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)	\$5,000	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)	\$5,000	
<b>Physician and other Health Professional Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Office Visits - Primary Doctor	\$15	\$20
Office Visits - Specialist	\$25	\$25
Radiation Therapy	\$25	\$25
Emergency Room (waived if admitted within 1 day)	\$75	
Urgent Care	\$55	
Ambulance	\$125	
<b>More than 20 Preventive Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full
<b>Hospital, Home Health Care, and Skilled Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital (Inpatient)	\$250 per stay	20%
Observation Room/Outpatient Surgery (Hospital)	\$150	\$200
Outpatient Surgery (Ambulatory Center)	\$125	\$175
Home Health Care	0%	\$10
Skilled Nursing Facility (100 days per benefit period)	\$10 per day 1-25/ \$0 per day 26-100	20% per day 1-100
Dialysis	\$0	Inside service area: 20% for non-participating providers. Outside service area: \$0 for non-participating providers.
<b>Mental Health/Chemical Dependence Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Mental Health (Inpatient, 190-day lifetime limit)	\$250 per stay	20%
Mental Health (Outpatient)	\$40	30%
Mental Health (Outpatient with Psychiatrist)	\$20	30%
Alcohol Substance Abuse (Inpatient)	\$250 per stay	20%
Alcohol Substance Abuse (Outpatient)	\$40	30%
<b>Laboratory and X-ray Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Laboratory Testing (Physician Office/Free Standing Lab)	\$10	\$25
Laboratory Testing (Outpatient Facility)	\$10	\$25
X-rays	\$35	\$35
Advanced Radiology (MRI, MRA, PET, and CT)	\$100	\$100
<b>Rehabilitation Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Physical, Occupational, and Speech Therapy	\$25	\$25
Chiropractor Medicare Covered	\$15	\$25
Acupuncture & Massage Therapy Annual Allowance	\$500	
Cardiac Rehab	\$25	\$25
<b>Vision</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Medical Vision Exam	\$25	\$25
Routine Vision Exam (Offered through Davis Vision)	\$25	20%

Annual allowance (lenses and frames) Offered through Davis Vision	\$200	
<b>Hearing</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Diagnostic Hearing Exam	\$25	\$25
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
<b>Dental</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Routine Dental Allowance	\$200	
<b>Supplies, Equipment, and Devices</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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%
<b>Fitness Program</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Highmark Fitness Program	National Fitness Network	
<b>Part B Drugs</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Immunosuppressive Drugs	0%	0%
Oral Chemotherapy Drugs	0%	0%
Physician Administered Injectables	0%	0%
Nebulizer Inhalation	0%	0%
Part B drugs (other)	0%	0%
<b>Value Added Rider</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Routine Chiropractic</b> - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 12 per calendar year.	\$15	\$25
<b>Routine Podiatry</b> - These are routine/not medically necessary services that are not covered by Original Medicare. Podiatry visits are limited to 3 visits per calendar year.	\$25	\$25
<b>Meal Plan</b> - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered in Full	Not Applicable
<b>Prescription Drugs - Part D</b>		
Prescription Deductible	Not Applicable	
True Out of Pocket (TrOOP) Costs Threshold	\$2,000	
Formulary	Fundamental	

<b>Retail Prescription Drugs (for up to a 31 day supply)</b>	<b>Preferred</b>	<b>Standard</b>
Tier 1 (Preferred Generic)	\$0	\$5
Tier 2 (Non-Preferred Generic)	\$10	\$15
Tier 3 (Preferred Brand & Generic)	\$30	\$35
Tier 4 (Non-Preferred)	\$50	\$55
Tier 5 (Specialty)	\$50	\$55
<b>Mail Order Prescription Drugs</b>	<b>Express Scripts</b>	<b>All other Mail Order Pharmacies</b>
Tier 1 (Preferred Generic)	\$0	\$10
Tier 2 (Non-Preferred Generic)	\$20	\$30
Tier 3 (Preferred Brand & Generic)	\$60	\$70
Tier 4 (Non-Preferred)	\$100	\$110
Tier 5 (Specialty)	\$50	\$55

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 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: Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

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

The Blue Shield(c) and Shield Symbol are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

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.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

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): 25FB0SF3

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