HIGHMARK. NORTHEASTERN NEW YORK

Medicare Sales: 1-855-215-9239 (TTY 711)

Monday-Friday: 8 a.m. - 5 p.m.

GROUP NAME: CASHIC - Mohonasen CSD Medicare

GROUP NUMBER: 10733445

PLAN NAME: Forever Blue 799 (PPO) Plan CF1 No Rx (2024)

Physician and other health professional services	In-Network	Out-of-Network
Primary doctor	$25	$30
Specialist	$40	$45
Radiation therapy	$40	$45
Emergency room (waived if admitted)	$50	$50
Urgent care (waived if admitted)	$50	$50
Ambulance	$50	$50
Telemedicine - Vendor	See Spec/MH Benefit	See Spec/MH Benefit

More than 20 preventive services	In-Network	Out-of-Network
Flu shots – Part B	Covered in full	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full	$45
All other preventive screenings and tests	Covered in full	$45

Hospital, home health care, and skilled services	In-Network	Out-of-Network
Hospital (inpatient)	$250 per stay	20%
Observation	$50	$75
Outpatient surgery — hospital	$50	$75
Outpatient surgery — ambulatory center	$50	$75
Home health care	Covered in full	$10
Skilled nursing facility (100 days per benefit period) -per stay	$20 a day 1-12	20%
Dialysis	Covered in full	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)	$250 per stay	20%
Mental health (outpatient)	$40	30%
Mental health (with psychiatrist)	$20	30%
Alcohol substance abuse (inpatient)	$250 per stay	20%
Alcohol substance abuse (outpatient)	20%	30%

Laboratory and X-ray services	In-Network	Out-of-Network
Laboratory testing	Covered in full	$45
X-rays	$40	$45
Advanced radiology – MRI, MRA, PET, and CT	$40	$45

Rehabilitation services	In-Network	Out-of-Network
Physical, occupational, and speech therapy	$40	$45
Chiropractor includes 12 routine visits	$20	$45
Acupuncture & Massage Therapy	$500 combined annual allowance	
Cardiac rehab	$30	$45

Vision	In-Network	Out-of-Network
Routine vision exam	$25	20%
Medical vision exam	$40	$45
Allowance (lenses and frames)	$200 annual allowance	

Hearing	In-Network	Out-of-Network
Routine hearing exam – TruHearing™	$45	$45
Diagnostic hearing exam	$40	$45
Hearing aid benefit – TruHearing™	$699/$999	

Dental	In-Network	Out-of-Network
Dental	$200 annual allowance	

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%
Diabetic supplies – Part B	Covered in full	30%

Fitness program	In-Network	Out-of-Network
SilverSneakers ("Steps" program included)®	Covered in full	

Prescription drugs – Part B	In-Network	Out-of-Network
Immunosuppressive drugs	Covered in full	Covered in full
Oral chemotherapy drugs	Covered in full	Covered in full
Physician administered injectables	Covered in full	Covered in full
Nebulizer inhalation solution	Covered in full	Covered in full
Part B drugs (other)	Covered in full	Covered in full

Prescription drugs – Part D	In-Network	Out-of-Network
Prescription drug (Rx)	Not Covered	
Mail order	Not Covered	
Shingles vaccine	Not Covered	
Coverage gap/donut hole	N/A	

General product information	In-Network	Out-of-Network
In-network out-of-pocket maximum	N/A	N/A
Combined out-of-pocket maximum	$3,400 Combined	
Prescription deductible	N/A	

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ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).
请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。