



**Medicare Advantage  
2026 Benefit Summary**

**Name: CASHIC - Schalmont CSD Medicare**

**Group Number: 10728345**

**Effective Date: 1/1/2026**

<b>Forever Blue 799 (PPO) Plan CF12 TRx</b>		
<b>Medical Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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
<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	\$15	20%
Radiation Therapy	\$20	\$20
Emergency Room (waived if admitted within 1 day)		\$50
Urgent Care		\$25
Ambulance (Emergent)		\$50
Ambulance (Non-Emergent)	\$50	\$50
<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)	\$0 per stay	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% days 1-100	20% days 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)	\$0 per stay	20%
Mental Health (Outpatient)	\$15	20%
Mental Health (Outpatient with Psychiatrist)	\$15	20%
Alcohol Substance Abuse (Inpatient)	\$0 per stay	20%
Alcohol Substance Abuse (Outpatient)	\$15	20%
<b>Laboratory and X-ray Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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%
<b>Rehabilitation Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Physical, Occupational, and Speech Therapy	\$15	20%
Chiropractor Medicare Covered	\$15	20%
Acupuncture & Massage Therapy Annual Allowance		\$500
Cardiac Rehab	\$15	20%
<b>Vision</b>	<b>In-Network</b>	<b>Out-of-Network</b>

Medical Vision Exam	\$15	20%
Routine Vision Exam (Offered through Davis Vision)	\$15	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	\$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. Up to 2 hearing aids per year.	Not Applicable
<b>Dental</b>		
Routine Dental		\$200 Allowance
<b>Supplies, Equipment, and Devices</b>	<b>In-Network</b>	<b>Out-of-Network</b>
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	0%	20%
<b>Fitness Program</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Highmark Fitness Program		Nationwide 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>
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 12 visits 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	Not Applicable
Over the Counter Drug Allowance	Not Covered	Not Applicable
<b>Prescription Drugs - Part D</b>		
True Out of Pocket (TrOOP) Costs Threshold		\$2,100
Formulary		Fundamental
Medicare Excluded Part D Prescription Drug Rider		Not Covered
Prescription Deductible		Not Applicable
<b>Retail Prescription Drugs (31 day supply)</b>	<b>Preferred</b>	<b>Standard</b>
Tier 1 (Preferred Generic)	\$0.00	\$5.00
Tier 2 (Non-Preferred Generic)	\$5.00	\$10.00
Tier 3 (Preferred Brand & Generic)	\$10.00	\$15.00
Tier 4 (Non-Preferred)	\$25.00	\$30.00
Tier 5 (Specialty)	\$25.00	\$30.00
<b>Mail Order Prescription Drugs</b>	<b>Express Scripts</b>	<b>All other Mail Order Pharmacies</b>
Tier 1 (Preferred Generic)	\$0.00	\$10.00
Tier 2 (Non-Preferred Generic)	\$10.00	\$20.00

Tier 3 (Preferred Brand & Generic)	\$20.00	\$30.00
Tier 4 (Non-Preferred)	\$50.00	\$60.00
Tier 5 (Specialty)	\$25.00	\$30.00
Retail and Mail Order Days Supply Limit	<ul style="list-style-type: none"> <li>- Retail or Mail Order -Tier 1 &amp; 2 - Up to a 100 day supply</li> <li>- Retail or Mail Order - Tier 3 &amp; 4 - Up to a 90 day supply</li> <li>- Specialty Drugs are limited to a 31-day supply</li> </ul>	
Catastrophic Phase	<p>After reaching the True Out of Pocket (TrOOP) costs of \$2,100, 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.</p>	

For questions about this plan's benefits or costs, please call 1-866-456-7739 (TTY 711), Monday -Friday 8 am - 4:30 pm.

Please have this number ready when you call **26FB0CF12**

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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)

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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