



**Medicare Advantage
2026 Benefit Summary**

Name: CASHIC - Schalmont CSD Medicare

Group Number: 10728335

Effective Date: 1/1/2026

	Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)	
Medical Benefits	In-Network	Out-of-Network
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)	\$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	\$20	\$20
Office Visits - Specialist	\$20	\$20
Radiation Therapy	\$20	\$20
Emergency Room (waived if admitted within 1 day)	\$50	
Urgent Care	\$35	
Ambulance (Emergent)	\$50	
Ambulance (Non-Emergent)	\$50	\$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 per stay	\$0 per stay
Observation Room/Outpatient Surgery (Hospital)	\$50	\$50
Outpatient Surgery (Ambulatory Center)	\$50	\$50
Home Health Care	0%	0%
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100	0% days 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 per stay	\$0 per stay
Mental Health (Outpatient)	\$40	\$40
Mental Health (Outpatient with Psychiatrist)	\$20	\$20
Alcohol Substance Abuse (Inpatient)	\$0 per stay	\$0 per stay
Alcohol Substance Abuse (Outpatient)	\$40	\$40
Laboratory and X-ray Services	In-Network	Out-of-Network
Laboratory Testing (Physician Office/Free Standing Lab)	\$0	\$0
Laboratory Testing (Outpatient Facility)	\$0	\$0
X-rays	\$20	\$20
Advanced Radiology (MRI, MRA, PET, and CT)	\$20	\$20
Rehabilitation Services	In-Network	Out-of-Network
Physical, Occupational, and Speech Therapy	\$20	\$20
Chiropractor Medicare Covered	\$20	\$20
Acupuncture & Massage Therapy Annual Allowance	\$500	
Cardiac Rehab	\$20	\$20
Vision	In-Network	Out-of-Network

Medical Vision Exam	\$20	\$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	\$20	\$20
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
Dental		
Routine Dental	\$200 Allowance	
Supplies, Equipment, and Devices	In-Network	Out-of-Network
Durable Medical Equipment	\$0 compression stockings; \$0 all other items	0%
Prosthetics	\$0 diabetic shoes/inserts; \$0 all other items	0%
Oxygen	0%	0%
Diabetic Supplies	0%	0%
Fitness Program	In-Network	Out-of-Network
Highmark Fitness Program	Nationwide 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 visits per calendar year.	\$20	\$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.	\$20	\$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
Prescription Drugs - Part D		
True Out of Pocket (TrOOP) Costs Threshold	\$2,100	
Formulary	Fundamental	
Medicare Excluded Part D Prescription Drug Rider	Not Covered	
Prescription Deductible	Not Applicable	
Retail Prescription Drugs (31 day supply)	Preferred	Standard
Tier 1 (Preferred Generic)	\$0.00	\$5.00
Tier 2 (Non-Preferred Generic)	\$10.00	\$15.00
Tier 3 (Preferred Brand & Generic)	\$25.00	\$30.00
Tier 4 (Non-Preferred)	\$40.00	\$45.00
Tier 5 (Specialty)	\$40.00	\$45.00
Mail Order Prescription Drugs	Express Scripts	All other Mail Order Pharmacies
Tier 1 (Preferred Generic)	\$0.00	\$10.00
Tier 2 (Non-Preferred Generic)	\$20.00	\$30.00

Tier 3 (Preferred Brand & Generic)	\$50.00	\$60.00
Tier 4 (Non-Preferred)	\$80.00	\$90.00
Tier 5 (Specialty)	\$40.00	\$45.00
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	
Catastrophic Phase	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.	

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 **26FB0DNU7**

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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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