



Medicare Advantage Renewal
2027 Renewal

Client Name: CASHIC-Schalmont CSD
Client Number: 296678
Group Number: 10728335

Effective Date: 1/1/2027

Medical Benefits	2026 Benefits		2027 Benefits	
	Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)	Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)	Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)	Forever Blue 799 (PPO) Plan DNU7 TRx (OOA)
Deductible	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0	\$0	\$0	\$0
Coinsurance (see specific benefits for cost sharing)	0%	0%	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	\$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		\$3,000	
Physician and other Health Professional Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Office Visits - Primary Doctor	\$20	\$20	\$20	\$20
Office Visits - Specialist	\$20	\$20	\$20	\$20
Radiation Therapy	\$20	\$20	\$20	\$20
Emergency Room (waived if admitted within 1 day)	\$50	\$50	\$50	\$50
Urgent Care	\$35	\$35	\$35	\$35
Ambulance (Emergency)	\$50	\$50	\$50	\$50
Ambulance (Non-Emergent)	\$50	\$50	\$50	\$50
More than 20 Preventive Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospital, Home Health Care, and Skilled Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital (Inpatient)	\$0 per stay	\$0 per stay	\$0 per stay	\$0 per stay
Observation Room/Outpatient Surgery (Hospital)	\$50	\$50	\$50	\$50
Outpatient Surgery (Ambulatory Center)	\$50	\$50	\$50	\$50
Home Health Care	0%	0%	0%	0%
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100	0% days 1-100	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.	\$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	In-Network	Out-of-Network
Mental Health (Inpatient, 190-day lifetime limit)	\$0 per stay	\$0 per stay	\$0 per stay	\$0 per stay
Mental Health (Outpatient)	\$40	\$40	\$40	\$40
Mental Health (Outpatient with Psychiatrist)	\$20	\$20	\$20	\$20
Alcohol Substance Abuse (Inpatient)	\$0 per stay	\$0 per stay	\$0 per stay	\$0 per stay
Alcohol Substance Abuse (Outpatient)	\$40	\$40	\$40	\$40
Laboratory and X-ray Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory Testing (Physician Office/Free Standing Lab)	\$0	\$0	\$0	\$0
Laboratory Testing (Outpatient Facility)	\$0	\$0	\$0	\$0
X-rays	\$20	\$20	\$20	\$20
Advanced Radiology (MRI, MRA, PET, and CT)	\$20	\$20	\$20	\$20
Rehabilitation Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Physical, Occupational, and Speech Therapy	\$20	\$20	\$20	\$20
Chiropractor Medicare Covered	\$20	\$20	\$20	\$20
Acupuncture & Massage Therapy Annual Allowance	\$500	\$500	Not Covered	Not Covered
Cardiac Rehab	\$20	\$20	\$20	\$20
Vision	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Vision Exam	\$20	\$20	\$20	\$20
Routine Vision Exam (Offered through Davis Vision)	\$15	20%	\$15	20%
Annual allowance (lenses and frames) Offered through Davis Vision	\$200	\$200	\$200	\$200
Hearing	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Hearing Exam	\$20	\$20	\$20	\$20
Routine Hearing Exam (TruHearing)	\$45	\$45	\$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	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.	\$500 maximum allowance combined in and out-of-network towards hearing aids that are not the Advanced or Premium models.
Dental	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Dental	\$200 Allowance	\$200 Allowance	\$200 Allowance	\$200 Allowance
Supplies, Equipment, and Devices	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment	\$0 compression stockings; \$0 all other items	0%	\$0 compression stockings; \$0 all other items	0%
Prosthetics	\$0 diabetic shoes/inserts; \$0 all other items	0%	\$0 diabetic shoes/inserts; \$0 all other items	0%
Oxygen	0%	0%	0%	0%
Diabetic Supplies	0%	\$0	0%	\$0
Fitness Program	In-Network	Out-of-Network	In-Network	Out-of-Network

Highmark Fitness Program	Nationwide Fitness Network		Nationwide Fitness Network	
Part B Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Immunosuppressive Drugs	0%	0%	0%	0%
Oral Chemotherapy Drugs	0%	0%	0%	0%
Physician Administered Injectables	0%	0%	0%	0%
Nebulizer Inhalation	0%	0%	0%	0%
Part B drugs (other)	0%	0%	0%	0%
Value Added Rider	In-Network	Out-of-Network	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	\$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	\$20	\$20
Meal Plan - 2 meals per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered for 1 meal per day up to 7 days	Not Applicable	Covered up to 2 meals per day up to 7 days	Not Applicable
Over the Counter Drug Allowance	Not Covered	Not Applicable	Not Covered	Not Applicable
Prescription Drugs - Part D	Fundamental		Performance	
True Out of Pocket (TrOOP) Costs Threshold	\$2,100		\$2,400	
Formulary	Not Covered		Not Covered	
Medicare Excluded Part D Prescription Drug Rider	Not Applicable		Not Applicable	
Prescription Deductible	Not Applicable		Not Applicable	
Retail Prescription Drugs (31 day supply)	Preferred	Standard	Preferred	Standard
Tier 1 (Preferred Generic)	\$0.00	\$5.00	\$0.00	\$5.00
Tier 2 (Non-Preferred Generic)	\$10.00	\$15.00	\$10.00	\$15.00
Tier 3 (Preferred Brand & Generic)	\$25.00	\$30.00	\$25.00	\$30.00
Tier 4 (Non-Preferred)	\$40.00	\$45.00	\$40.00	\$45.00
Tier 5 (Specialty)	\$40.00	\$45.00	\$40.00	\$45.00
Mail Order Prescription Drugs	Express Scripts	Pharmacies	Express Scripts	Pharmacies
Tier 1 (Preferred Generic)	\$0.00	\$10.00	\$0.00	\$10.00
Tier 2 (Non-Preferred Generic)	\$20.00	\$30.00	\$20.00	\$30.00
Tier 3 (Preferred Brand & Generic)	\$50.00	\$60.00	\$50.00	\$60.00
Tier 4 (Non-Preferred)	\$80.00	\$90.00	\$80.00	\$90.00
Tier 5 (Specialty)	\$40.00	\$45.00	\$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		- 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.		After reaching the True Out of Pocket (TrOOP) costs of \$2,400, 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.	
Total Premium Per Member, Per Month	\$460		\$601	

This is a summary of the most commonly used benefits. It does not include a full list of benefits.

Please return to your Senior Markets Client Manager copies to 1-833-841-8072

Signature

Rachael France

Date

9/29/2026

Printed Name

Rachael France

Title

District Treasurer

EGHP_24_3569_M

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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.

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Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6950 (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.

我提供免費的諮詢服務，以回答您對我們的醫療計劃或藥物有任何問題。如果您需要一名翻譯人員，請撥打與您的居住州對應的電話號碼。說西班牙語的人可以幫助您。此服務是免費的。

The premiums reflected on this document do NOT include the \$7.50 pcpm Amsure Fee