

**Suggested Plan: Forever Blue 799 (PPO) Plan 34**

<b>Monthly premium effective January 1, 2024</b>	<b>Cost</b>
	<b>\$430.00</b>

	Current		Upon renewal	
<b>Physician and other health professional services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Primary doctor/Specialist	\$15 / \$35	\$20 / \$40	\$15 / \$35	\$20 / \$40
Radiation therapy	\$35	\$40	\$35	\$40
Emergency room (waived if admitted)	\$75	\$75	\$75	\$75
Urgent care (waived if admitted)	\$65	\$65	\$65	\$65
Ambulance	\$125	\$125	\$125	\$125
<b>More than 20 preventive services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Flu shots - Part B	Covered in full	Covered in full	Covered in full	Covered in full
Immunizations - Part B (hepatitis/pneumonia)	Covered in full	\$40	Covered in full	\$40
All other preventive screenings and tests	Covered in full	\$40	Covered in full	\$40
<b>Hospital, home health care, and skilled services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Hospital (inpatient)	\$350 per stay	30%	\$350 per stay	30%
Outpatient surgery - hospital	\$175	\$200	\$175	\$200
Outpatient surgery - ambulatory center	\$75	\$175	\$75	\$175
Home health care	\$10	30%	\$10	30%
Skilled nursing facility - Per Stay	\$350 per stay	30%	\$10 per day-day 1-20 \$50 per day- day 21-23	30%
Dialysis	Covered in full	Inside service area: 20% for non-participating providers. Outside service area: \$0 for non-participating providers.	Covered in full	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>	<b>In-Network</b>	<b>Out-of-Network</b>
Mental health (inpatient, 190-day lifetime limit)	\$350 per stay	30%	\$350 per stay	30%
Mental health (outpatient)	\$35	30%	\$35	30%
Mental health (with psychiatrist)	\$20	30%	\$20	30%
Alcohol substance abuse (inpatient)	\$350 per stay	30%	\$350 per stay	30%
Alcohol substance abuse (outpatient)	20%	30%	20%	30%
<b>Laboratory and X-ray services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Laboratory testing	\$5	\$40	\$5	\$40
X-rays	\$35	30%	\$35	30%
Advanced radiology - MRI, MRA, PET, and CT	\$50	30%	\$50	30%
<b>Rehabilitation services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Physical, occupational, and speech therapy	\$35	\$40	\$35	\$40
Acupuncture & Massage Therapy	\$500 annual allowance		\$500 annual allowance	
Chiropractor	\$20 includes 12 routine visits	\$40 includes 12 routine visits	\$20 includes 12 routine visits	\$40 includes 12 routine visits

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Cardiac rehab	\$30	\$40	\$30	\$40
Vision	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine vision exam	\$25	20%	\$25	20%
Allowance (lenses and frames)	\$300 annual allowance		\$300 annual allowance	
Hearing	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine hearing exam - TruHearing™	\$45	\$45	\$45	\$45
Hearing aid benefit - TruHearing™	\$499 / \$799		\$499 / \$799	
Dental	In-Network	Out-of-Network	In-Network	Out-of-Network
Dental allowance	\$300 annual allowance		\$300 annual allowance	
Supplies, equipment and devices	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable medical equipment	\$0 compression stockings; 20% all other items	30%	\$0 compression stockings; 20% all other items	30%
Prosthetics	\$0 diabetic shoes/inserts; 20% all other items	30%	\$0 diabetic shoes/inserts; 20% all other items	30%
Diabetic supplies - Part B	Covered in full	30%	Covered in full	30%
Fitness program	In-Network	Out-of-Network	In-Network	Out-of-Network
SilverSneakers® ("Steps" program included)	Covered in full		Covered in full	
Prescription drugs - Part B	In-Network	Out-of-Network	In-Network	Out-of-Network
Immunosuppressive drugs	Covered in full	Covered in full	Covered in full	Covered in full
Oral chemotherapy drugs	Covered in full	Covered in full	Covered in full	Covered in full
Physician administered injectables	Covered in full	Covered in full	Covered in full	Covered in full
Nebulizer inhalation solution	Covered in full	Covered in full	Covered in full	Covered in full
Part B drugs - other	Covered in full	Covered in full	Covered in full	Covered in full
Prescription drugs - Part D	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription drug (Rx)	\$0/\$20/\$45/\$95/\$95		\$0/\$20/\$45/\$95/\$95	
Mail order (90-day supply)	Tier 1 - Tier 4: 2 copays for a 90 day supply		2 copays for: Tiers 1-2 100-day supply Tiers 3-4 90 day supply	
Coverage gap/donut hole	No coverage gap		No coverage gap	
General product information	In-Network	Out-of-Network	In-Network	Out-of-Network
In-network out-of-pocket maximum	\$3,400	N/A	\$3,400	N/A
Combined out-of-pocket maximum	\$5,100 Combined		\$5,100 Combined	
RX deductible	N/A		N/A	