



**Now Serving the Following
Massachusetts Counties:**

Suffolk
Worcester
Middlesex
Bristol*
Norfolk*
Plymouth*

*New counties for 2024

2024 Benefits at A Glance.

For agent use only. Not to be distributed
or shared with Medicare beneficiaries.

Plan Costs	Forever (HMO)		ForeverMore (HMO)		Freedom (PPO)		Give Back (PPO)	
	In-Network		In-Network		In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$0		\$25		\$0		\$0	
MOOP	\$5,800		\$4,500		\$6,000	\$9,000	\$6,500	\$10,000
Part B Give Back	N/A		N/A		N/A		\$80	
Medical Deductible	N/A		N/A		N/A		N/A	
INPATIENT CARE								
Inpatient Hospital	\$350; Days 1-5		\$200; Days 1-5		\$370; Days 1-5	40% coinsurance	\$430; Days 1-4	40% coinsurance
Inpatient Mental	\$350, Days 1-5		\$200, Days 1-5		\$370, Days 1-5	40% coinsurance	\$430, Days 1-4	40% coinsurance
Skilled Nursing Facility	\$0, Days 1-20 \$203, Days 21-100		\$0, Days 1-20 \$203, Days 21-100		\$0, Days 1-20 \$203, Days 21-100	30% coinsurance	\$0, Days 1-20 \$203, Days 21-100	30% coinsurance
OUTPATIENT CARE								
Primary Care Visit	\$0		\$0		\$0		\$0	
Specialist Visit	\$0		\$0		\$0	\$20	\$0	\$20
Chiropractor Visit	\$15		\$15		\$15	30% coinsurance	\$15	30% coinsurance
Podiatry Visit	\$35		\$25		\$35	30% coinsurance	\$35	30% coinsurance
Outpatient Mental Health	\$0 for office visits up to 15 minutes \$25 for each individual/group therapy visit		\$0 for office visits up to 15 minutes \$25 for each individual/group therapy visit		\$0 for office visits up to 15 minutes \$25 for each individual/group therapy visit	\$50 copay for Mental Health Specialty Services 30% coinsurance for Psychiatric Services	\$0 for office visits up to 15 minutes \$40 for each individual/group therapy visit	\$50 copay for Mental Health Specialty Services 30% coinsurance for Psychiatric Services
Outpatient Substance Abuse	\$20		\$15		\$25	\$50	\$25	\$50
Ambulatory Surgery	\$225		\$200		\$250	30% coinsurance	\$250	30% coinsurance
Outpatient Hospital	\$325		\$250		\$350	40% coinsurance	\$350	40% coinsurance
Ambulance Ground/Air	\$300		\$250		\$300		\$300	
Emergency Care	\$100		\$120		\$100		\$100	
Worldwide ER Care	\$100		\$120		\$100		\$100	
Urgently Needed Care	\$0 for PCP related services \$25 for all other		\$0 for PCP related services \$25 for all other		\$0 for PCP related services \$25 for all other		\$0 for PCP related services \$25 for all other	
Home Health	\$0		\$0		\$0	30% coinsurance	\$0	30% coinsurance
OUTPATIENT MEDICAL SERVICES AND SUPPLIES								
DME	20%		20%		20%	30% coinsurance	20%	30% coinsurance
Diabetic Supplies	\$0 for preferred manufacturers 20% for all others		\$0 for preferred manufacturers 20% for all others		\$0 for preferred manufacturers 20% for all others	30% coinsurance	\$0 for preferred manufacturers 20% for all others	30% coinsurance
Diagnostic Lab	\$0 at office \$10 at free standing lab facility		\$0 at office \$10 at free standing lab facility		\$0 at office \$10 at free standing lab facility	30% coinsurance	\$0 at office \$10 at free standing lab facility	30% coinsurance
Diagnostic Procedures	\$0 at office \$10 at free standing lab facility		\$0 at office \$10 at free standing lab facility		\$0 at office \$30 at free standing lab facility	30% coinsurance	\$0 at office \$40 at free standing lab facility	30% coinsurance
Diagnostic Radiology	\$125 for ultrasound \$300 for all others		\$100 for ultrasound \$200 for all others		\$150 for ultrasound \$300 for all others	30% coinsurance	\$150 for ultrasound \$350 for all others	30% coinsurance
X-Ray	\$10		\$5		\$15	30% coinsurance	\$20	30% coinsurance
Diagnostic Colonoscopy	\$0		\$0		\$0	30% coinsurance when performed at ASC. 40% coinsurance when performed at an Outpatient Hospital.	\$0	30% coinsurance when performed at ASC. 40% coinsurance when performed at an Outpatient Hospital.
Therapeutic Radiology	\$60		\$60		\$60	30% coinsurance	20% coinsurance	30% coinsurance
PREVENTATIVE SERVICES								
Preventative Services	\$0		\$0		\$0	30% coinsurance	\$0	30% coinsurance
PART D								
Deductible	\$185 (tiers 3-5)		\$170 (tiers 3-5)		\$185 (tiers 3-5)		\$300 (tiers 3-5)	
	Retail (30d 100d)	Mail (30d 100d)	Retail (30d 100d)	Mail (30d 100d)	Retail (30d 100d)	Mail (30d 100d)	Retail (30d 100d)	Mail (30d 100d)
Tier 1	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0
Tier 2	\$5 15	\$5 \$5	\$5 \$15	\$5 \$5	\$5 15	\$5 \$5	\$5 \$15	\$5 \$5
Tier 3	\$47 \$141	\$47 \$47	\$47 \$141	\$47 \$47	\$47 \$141	\$47 \$47	\$47 \$141	\$47 \$47
Tier 4	\$100 \$300	\$100 \$300	\$100 \$300	\$100 \$300	\$100 \$300	\$100 \$300	\$100 \$300	\$100 \$300
Tier 5	30% N/A	30% N/A	30% N/A	30% N/A	30% N/A	30% N/A	28% N/A	28% N/A
Insulin	\$35 \$105	\$35 \$35	\$35 \$105	\$35 \$35	\$35 \$105	\$35 \$35	\$35 \$105	\$35 \$35
EXTRA BENEFITS								
Dental	\$4,000 annual allowance		\$4,500 annual allowance		\$4,000 annual allowance		\$3,500 annual allowance	
Vision	\$0 Routine Vision Exam \$15 Medicare Covered Exam \$200 Eyewear Allowance Annually		\$0 Routine Vision Exam \$15 Medicare Covered Exam \$200 Eyewear Allowance Annually		\$0 Routine Vision Exam \$15 Medicare Covered Exam \$200 Eyewear Allowance Annually		\$0 Routine Vision Exam \$45 Medicare Covered Exam \$200 Eyewear Allowance Annually	
Hearing	\$0 Routine Hearing Exam \$15 Medicare Covered Exam \$595/\$895 Per Ear Annually		\$0 Routine Hearing Exam \$15 Medicare Covered Exam \$595/\$895 Per Ear Annually		\$0 Routine Hearing Exam \$15 Medicare Covered Exam \$595/\$895 Per Ear Annually		\$0 Routine Hearing Exam \$45 Medicare Covered Exam \$595/\$895 Per Ear Annually	
OTC	\$60 Quarterly		\$50 Quarterly		\$50 Quarterly		\$30 Quarterly	

Healthy Grocery*	\$60 Quarterly which can combine with OTC allowance	\$70 Quarterly which can combine with OTC allowance	\$60 Quarterly which can combine with OTC allowance	N/A
Transportation	Unlimited transportation to and from the pharmacy and medical appointments at no additional cost.			
In-Home Support	Up to 60 hours annually for assistance with household chores, technical assistance, and general companionship. Virtual companionship is also available.			
Fitness	Access to national and boutique fitness facilities, on-demand classes, social activities, brain training, and at-home fitness kits.			
PERS	Fully covered monthly subscription. (In-home, Mobile LTE, and LTE Smartwatch options)			

*Members must qualify to receive this benefit. Not all members will qualify.