BlueCross BlueShield of Western New York

Medicare Sales: 1-855-215-9237 (TTY 711)

Monday-Friday: 8 a.m. - 5 p.m.

GROUP NAME: Bar Association of Erie County Retirees

GROUP NUMBER: 00403921

PLAN NAME: Forever Blue 799 (PPO) Plan 13 (OOA) (2020)

Physician and other health professional services	In-Network	Out-of-Network
Primary doctor	$10	$10
Specialist	$20	$20
Radiation therapy	$20	$20
Emergency room (waived if admitted)	$50	$50
Urgent care (waived if admitted)	$50	$50
Ambulance	$50	$50
Telemedicine – Doctor on Demand®	Covered in full	Covered in full

More than 20 preventive services	In-Network	Out-of-Network
Flu shots – Part B	Covered in full	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full	Covered in full
All other preventive screenings and tests	Covered in full	Covered in full

Hospital, home health care, and skilled services	In-Network	Out-of-Network
Hospital (inpatient)	$250 / 1 copay max per year combined	$250 / 1 copay max per year combined
Observation	$50	$50
Outpatient surgery – hospital	$50	$50
Outpatient surgery – ambulatory center	$35	$35
Home health care	Covered in full	Covered in full
Skilled nursing facility (100 days per benefit period)	$250 / 1 copay max per year combined	$250 / 1 copay max per year combined
Dialysis	Covered in full	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)	$250 / 1 copay max per year combined	$250 / 1 copay max per year combined
Mental health (outpatient)	$40	$40
Mental health (with psychiatrist)	$20	$20
Alcohol substance abuse (inpatient)	$250 / 1 copay max per year combined	$250 / 1 copay max per year combined
Alcohol substance abuse (outpatient)	20%	20%

Laboratory and X-ray services	In-Network	Out-of-Network
Laboratory testing	Covered in full	Covered in full
X-rays	$20	$20

Advanced radiology – MRI, MRA, PET, and CT	$30	$30
Rehabilitation services	In-Network	Out-of-Network
Physical, occupational, and speech therapy	$20	$20
Chiropractor	$20	$20
Cardiac rehab	$20	$20
Vision	In-Network	Out-of-Network
Routine vision exam	$15	20%
Medical vision exam	$20	$20
Allowance (lenses and frames)	$200 annual allowance	
Hearing	In-Network	Out-of-Network
Routine hearing exam – TruHearing™	$45	$45
Diagnostic hearing exam	$20	$20
Hearing aid benefit – TruHearing™	$699/$999	
Dental	In-Network	Out-of-Network
Dental	$200 annual allowance	
Supplies, equipment, and devices	In-Network	Out-of-Network
Durable medical equipment	$0 compression stockings; 20% all other items	20%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	20%
Diabetic supplies – Part B	Covered in full	Covered in full
Fitness program	In-Network	Out-of-Network
SilverSneakers (“Steps” program included)®	Covered in full	
Prescription drugs – Part B	In-Network	Out-of-Network
Immunosuppressive drugs	Covered in full	Covered in full
Oral chemotherapy drugs	Covered in full	Covered in full
Physician administered injectables	Covered in full	20%
Nebulizer inhalation solution	20%	20%
Part B drugs (other)	20%	20%
Prescription drugs – Part D	In-Network	Out-of-Network
Prescription drug (Rx)	$0/$10/$20/$40/$40	
Mail order	Tier 1 - Tier 5: 2 copays for a 90 day supply	
Shingles vaccine	Covered in full	
Coverage gap/donut hole	No coverage gap	
General product information	In-Network	Out-of-Network
In-network out-of-pocket maximum	$3,400	N/A
Combined out-of-pocket maximum	$3,400	
Prescription deductible	N/A	

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