Medicare Advantage
2027 Benefit Summary

Name: Bar Association fo Erie County Medicare
Group Number: 10725045
Effective Date: 1/1/2027

	Forever Blue 799 (PPO) Plan 34	
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)	$3,400	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)	$5,100	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$15	$20
Office Visits - Specialist	$35	$40
Radiation Therapy	$35	$40
Emergency Room (waived if admitted within 1 day)	$75	
Urgent Care	$65	
Ambulance (Emergent)	$125	
Ambulance (Non-Emergent)	$125	$125
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)	$350 per stay	30%
Observation Room/Outpatient Surgery (Hospital)	$175	$200
Outpatient Surgery (Ambulatory Center)	$75	$175
Home Health Care	$10	30%
Skilled Nursing Facility (100 days per benefit period)	$10 days 1-20/ $50 days 21-23/ $0 days 24-100	30% 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)	$350 per stay	30%
Mental Health (Outpatient)	$35	30%
Mental Health (Outpatient with Psychiatrist)	$20	30%
Alcohol Substance Abuse (Inpatient)	$350 per stay	30%
Alcohol Substance Abuse (Outpatient)	$35	30%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$5	$40
Laboratory Testing (Outpatient Facility)	$5	$40
X-rays	$35	30%
Advanced Radiology (MRI, MRA, PET, and CT)	$50	30%
Rehabilitation Services	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$35	$40
Chiropractor Medicare Covered	$20	$40
Acupuncture & Massage Therapy Annual Allowance	Not Covered	
Cardiac Rehab	$30	$40
Vision	**In-Network**	**Out-of-Network**
Medical Vision Exam	$35	$40

Routine Vision Exam (Offered through Davis Vision)	$25	20%
Annual allowance (lenses and frames) Offered through Davis Vision	$300	
Hearing	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$35	$40
Routine Hearing Exam (TruHearing)	$45	$45
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a $499 copay for the Advanced or a $799 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		
Routine Dental	$300 Allowance	
Supplies, Equipment, and Devices	**In-Network**	**Out-of-Network**
Durable Medical Equipment	$0 compression stockings; 20% all other items	30%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	30%
Oxygen	20%	30%
Diabetic Supplies	0%	30%
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	$40
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.	$35	$40
Meal Plan - 2 meals 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	$2,400	
Formulary	Performance	
Medicare Excluded Part D Prescription Drug Rider	Not Covered	
Prescription Deductible	Not Applicable	
Retail Prescription Drugs (31 day supply)		
Tier 1 (Preferred Generic)	$0.00	
Tier 2 (Non-Preferred Generic)	$20.00	
Tier 3 (Preferred Brand & Generic)	$45.00	
Tier 4 (Non-Preferred)	$95.00	
Tier 5 (Specialty)	$95.00	
Mail Order Prescription Drugs		
Tier 1 (Preferred Generic)	$0.00	
Tier 2 (Non-Preferred Generic)	$40.00	
Tier 3 (Preferred Brand & Generic)	$90.00	
Tier 4 (Non-Preferred)	$190.00	
Tier 5 (Specialty)	$95.00	
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 $2,400, 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.

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 27FB034

EGHP_24_9270_M

Highmark Blue Cross Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal. Benefits and/or benefit administration may be provided by or through the following entities,
which are independent licensees of the Blue Cross Blue Shield Association:
Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, or Highmark Senior Health Company.
Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield.
West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company.
All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.
The Blue Cross(c), Blue Shield(c), Cross, and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
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.
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.
我们免费提供口译服务，为您解答有关我们健康计划或药物 计划的任何疑问。如需口译服务，只需拨打您所在州相应的 电话号码即可。说中文的工作人员可为您提供帮助。此项服务免 费。