BlueCross BlueShield of Western New York

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

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

GROUP NAME: Williamsville Teachers' Association Retirees

PLAN NAME:	Senior Blue 699 (HMO) Plan 4 (2021) $459	Senior Blue 699 (HMO) Plan 37 (2021) $370	Forever Blue 799 (PPO) Plan 10 (2021) $493	
Physician and other health professional services	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Primary doctor	$5	$30	$5	$20
Specialist	$20	$45	$15	$20
Radiation therapy	$20	$20	$15	$20
Emergency room (waived if admitted)	$50	$75	$50	$50
Urgent care (waived if admitted)	$50	$65	$50	$50
Ambulance	$25	$150	$25	$25
Telemedicine – Doctor on Demand®	Covered in full	Covered in full	Covered in full	Covered in full
More than 20 preventive services	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Flu shots – Part B	Covered in full	Covered in full	Covered in full	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full	Covered in full	Covered in full	$20
All other preventive screenings and tests	Covered in full	Covered in full	Covered in full	$20
Hospital, home health care, and skilled services	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Hospital (inpatient)	Covered in full per stay	$500 / 1 copay max per year	$100 / 1 copay max per year	20%
Observation	$50	$75	$50	$50
Outpatient surgery – hospital	$50	$350	$35	$50
Outpatient surgery – ambulatory center	$50	$250	$35	$50
Home health care	Covered in full	Covered in full	Covered in full	$10
Skilled nursing facility (100 days per benefit period)	Covered in full per stay	$500 / 1 copay max per year	$100 / 1 copay max per year	20%
Dialysis	Covered in full	Covered in full	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**	**In-Network**	**In-Network**	**Out-of-Network**
Mental health (inpatient, 190-day lifetime limit)	Covered in full per stay	$500 / 1 copay max per year	$100 / 1 copay max per year	20%
Mental health (outpatient)	$40	$40	$40	30%
Mental health (with psychiatrist)	$20	$40	$20	30%
Alcohol substance abuse (inpatient)	Covered in full per stay	$500 / 1 copay max per year	$100 / 1 copay max per year	20%
Alcohol substance abuse (outpatient)	20%	20%	20%	30%
Laboratory and X-ray services	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Laboratory testing	Covered in full	$5	Covered in full	$20
X-rays	$20	$45	$15	$20
Advanced radiology – MRI, MRA, PET, and CT	$20	$100	$15	$20
Rehabilitation services	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Physical, occupational, and speech therapy	$20	$20	$15	$20
Chiropractor	$20	$20	$15	$20
Cardiac rehab	$20	$20	$15	$20
Vision	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Routine vision exam	$15	$25	$15	20%
Medical vision exam	$20	$45	$15	$20
Allowance (lenses and frames)	$200 annual allowance	$200 annual allowance	$200 annual allowance	
Hearing	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Routine hearing exam – TruHearing™	$45	$45	$45	$45
Diagnostic hearing exam	$20	$45	$15	$20
Hearing aid benefit – TruHearing™	$699/$999	$699/$999	$699/$999	
Dental	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Dental	$200 annual allowance	$200 annual allowance	$200 annual allowance	
Supplies, equipment, and devices	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Durable medical equipment	$0 compression stockings; 20% all other items	$0 compression stockings; 20% all other items	$0 compression stockings; 20% all other items	30%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	$0 diabetic shoes/inserts; 20% all other items	$0 diabetic shoes/inserts; 20% all other items	30%
Diabetic supplies – Part B	Covered in full	Covered in full	Covered in full	30%
Fitness program	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
SilverSneakers ("Steps" program included)®	Covered in full	Covered in full	Covered in full	
Prescription drugs – Part B	**In-Network**	**In-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	20%
Nebulizer inhalation solution	20%	20%	20%	20%
Part B drugs (other)	20%	20%	20%	30%

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Prescription drugs – Part D	In-Network	In-Network	In-Network	Out-of-Network
Prescription drug (Rx)	$0/$10/$20/$40/$40	$0/$20/$45/$95/$95	$0/$7/$25/$40/$40	
Mail order	Tier 1 - Tier 5: 2 copays for a 90 day supply	Tier 1 - Tier 5: 2.5 copays for a 90 day supply	Tier 1 - Tier 5: 2 copays for a 90 day supply	
Shingles vaccine	Covered in full	Covered in full	Covered in full	
Coverage gap/donut hole	No coverage gap	No coverage gap	No coverage gap	
General product information	In-Network	In-Network	In-Network	Out-of-Network
In-network out-of-pocket maximum	$3,000	$4,000	$3,000	N/A
Combined out-of-pocket maximum	N/A	N/A	$3,000	
Prescription deductible	N/A	N/A	N/A	

BlueCross BlueShield of Western New York (BCBSWNY) is a Medicare Advantage plan with a Medicare contract and enrollment

depends on contract renewal. BCBSWNY is a division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association. SilverSneakers® is a registered trademark of Ti administers the SilverSneakers gym benefit. Doctor On Demand® is a separate company that provides telemedicine services to BCBSWNY members. TruHearing® is a registered trademark of TruHearin hearing-aid benefit. Other pharmacies/physicians/providers are available in our network. Out-of-network/non- contracted providers are under no obligation to treat BlueCross BlueShield of Western N customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services. BCBSWNY complies with applicable Federal civil rig national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística, Llame al 1-833-735-4515 (TTY 711) 注意：如果您使用繁體中文，

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

GROUP NAME: Williamsville Teachers' Association Retirees

PLAN NAME:

	Forever Blue 799 (PPO) Plan 34 (2021) $433	
Physician and other health professional services	**In-Network**	**Out-of-Network**
Primary doctor	$15	$20
Specialist	$35	$40
Radiation therapy	$35	$40
Emergency room (waived if admitted)	$75	$75
Urgent care (waived if admitted)	$65	$65
Ambulance	$125	$125
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	$40
All other preventive screenings and tests	Covered in full	$40
Hospital, home health care, and skilled services	**In-Network**	**Out-of-Network**
Hospital (inpatient)	$350 per stay	30%
Observation	$75	$75
Outpatient surgery – hospital	$175	$200
Outpatient surgery – ambulatory center	$75	$175
Home health care	$10	30%
Skilled nursing facility (100 days per benefit period)	$350 per stay	30%
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)	$350 per stay	30%
Mental health (outpatient)	$35	30%
Mental health (with psychiatrist)	$20	30%
Alcohol substance abuse (inpatient)	$350 per stay	30%
Alcohol substance abuse (outpatient)	20%	30%
Laboratory and X-ray services	**In-Network**	**Out-of-Network**
Laboratory testing	$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	$20	$40
Cardiac rehab	$30	$40
Vision	**In-Network**	**Out-of-Network**
Routine vision exam	$25	20%
Medical vision exam	$35	$40
Allowance (lenses and frames)	$200 annual allowance	
Hearing	**In-Network**	**Out-of-Network**
Routine hearing exam – TruHearing™	$45	$45
Diagnostic hearing exam	$35	$40
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	30%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	30%
Diabetic supplies – Part B	Covered in full	30%
Fitness program	**In-Network**	**Out-of-Network**
SilverSneakers ("Steps" program included)®	Covered in full	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	30%
Nebulizer inhalation solution	20%	30%
Part B drugs (other)	20%	30%

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PLAN NAME:	Forever Blue 799 (PPO) Plan 34 (2021) $433	
Prescription drugs – Part D	**In-Network**	**Out-of-Network**
Prescription drug (Rx)	$0/$20/$45/$95/$95	
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	$5,100 Combined	
Prescription deductible	N/A	

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