BlueCross BlueShield of Western New York

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

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

PLAN NAME: BlueCross BlueShield Forever Blue 751 (PPO) (2020)

Physician and other health professional services	In-Network	Out-of-Network
Primary doctor	$5	25%
Specialist	$27	25%
Radiation therapy	20%	25%
Emergency room (waived if admitted)	$90	$90
Urgent care (waived if admitted)	$65	$65
Ambulance	$250	$250
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	25%
Immunizations – Part B (hepatitis/pneumonia)	Covered in full	25%
All other preventive screenings and tests	Covered in full	25%
Hospital, home health care, and skilled services	In-Network	Out-of-Network
Hospital (inpatient)	$205 per day for days 1-7, $1,435 OOP Max per year	30%
Observation	$200	25%
Outpatient surgery – hospital	$300	25%
Outpatient surgery – ambulatory center	$200	25%
Home health care	Covered in full	25%
Dialysis	20%	Inside service area: 50% for non-participating providers. Outside service area: 20% for non-participating providers.
Skilled nursing facility (100 days per benefit period)	$0 per day for days 1-20; $178.00 per day for days 21-100. No yearly benefit period maximum.	30%
Mental health / chemical dependence services	In-Network	Out-of-Network
Mental health (inpatient, 190-day lifetime limit)	$270 per day for days 1-6, $1,620 OOP Max per year	30%
Mental health (outpatient)	$40	50%
Mental health (with psychiatrist)	$40	50%

Alcohol substance abuse (inpatient)	$270 per day for days 1-6, $1,620 OOP Max per year	30%
Alcohol substance abuse (outpatient)	50%	50%
Laboratory and X-ray services	In-Network	Out-of-Network
Laboratory testing	$5	25%
X-rays	$40	25%
Advanced radiology – MRI, MRA, PET, and CT	$150	25%
Rehabilitation services	In-Network	Out-of-Network
Physical, occupational, and speech therapy	$25	25%
Chiropractor	$20	25%
Cardiac rehab	$15	25%
Vision	In-Network	Out-of-Network
Routine vision exam	$25	20%
Medical vision exam	$27	25%
Allowance (lenses and frames)	$100 annual allowance	
Hearing	In-Network	Out-of-Network
Routine hearing exam – TruHearing™	$45	$45
Diagnostic hearing exam	$27	25%
Hearing aid benefit – TruHearing™	$699/$999	
Dental	In-Network	Out-of-Network
Dental	Preventive dental (routine cleanings, oral exams & x-rays) $10 per service	
Supplies, equipment, and devices	In-Network	Out-of-Network
Durable medical equipment	$0 compression stockings; 20% all other items	50%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	50%
Diabetic supplies – Part B	Covered in full	50%
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	20%	25%
Oral chemotherapy drugs	20%	25%
Physician administered injectables	20%	25%
Nebulizer inhalation solution	$25	25%
Part B drugs (other)	20%	25%
Prescription drugs – Part D	In-Network	Out-of-Network
Prescription drug (Rx)	Preferred pharmacies: $2/$8/$42/$94/33% Standard pharmacies: $7/$13/$47/$99/33%	

Mail order	Tier 1: $0 copay for a 90 day supply; Tier 2 - Tier 4: 2.5 copays for a 90 day supply; Tier 5: 33% of the cost of the fill up to a 90 day supply. There is only one participating pharmacy for mail order (ESI) so there is no network.
Shingles vaccine	Preferred pharmacies: $2 Standard pharmacies: $7
Coverage gap/donut hole	Discounts only

General product information	In-Network	Out-of-Network
In-network out-of-pocket maximum	$6,700	N/A
Combined out-of-pocket maximum	$10,000 Combined	
Prescription deductible	N/A	

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