

2022 Summary of Benefits



Cobleskill CSD Retirees/1144888
 Forever Blue 799 (PPO) Plan CF38 TRx (2022)
 PPO-H5526 808

This is a summary of drug and health services covered by Forever Blue 799 (PPO) Plan CF38 TRx (2022)

January 1, 2022 – December 31, 2022

Forever Blue 799 (PPO) Plan CF38 TRx (2022) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service that we cover, limitation, or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join **Forever Blue 799 (PPO) Plan CF38 TRx (2022)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and your former employer must reside in our service area. Our service area includes the following counties in New York State: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren and Washington.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services. If you see a provider who participates in the Medicare Advantage PPO Network Sharing Program outside of our service area, you pay your in-network copay. If you receive care from out-of-network providers, your cost may be higher.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is also available in large print.

Please call us at 1-855-215-9239 (TTY 711) or visit us at bsneny.com/medicare.

Our office hours are:
 Monday-Friday: 8 a.m. - 5 p.m.

Premiums and Benefits	Forever Blue 799 (PPO) Plan CF38 TRx (2022)	
	In-Network	Out-of-Network
Monthly plan premium	*If you currently pay a premium for your coverage please reach out to your Group Benefit Administrator to find out your cost.	
Deductible	This plan does not have a medical deductible	
Maximum out-of-pocket responsibility (does not include prescription drugs)	You pay no more than \$4,500 annually Includes copays and other costs for medical services for the year.	You pay no more than \$4,500 annually Includes copays and other costs for medical services for the year.
Inpatient hospital	You pay \$0 per stay Services may require a prior authorization	You pay \$0 per stay

Premiums and Benefits	Coverage for 2019 (PPO Plan) (Effective 1/1/2019)	
Outpatient hospital	You pay \$0 Services may require a prior authorization	You pay \$0
Doctor visit Primary Specialist	You pay \$15 You pay \$15	You pay \$20 You pay \$20
Preventive care (e.g. flu vaccine, diabetic screenings)	You pay \$0	You pay \$0
Emergency care	You pay \$0 if you are admitted to the hospital within 1 day, then you do not have to pay \$0	You pay \$0 if you are admitted to the hospital within 1 day, then you do not have to pay \$0
Surgery – ambulatory center	You pay \$0 Services may require a prior authorization	You pay \$0
Urgently needed services	You pay \$0 If you are admitted to the hospital within 1 day, then you do not have to pay \$0	You pay \$0 If you are admitted to the hospital within 1 day, then you do not have to pay \$0
Diagnostic services/labs/imaging Diagnostic and procedures Lab services Advanced radiology – MRI, MRA, PET, and CT Outpatient X-Rays Therapeutic radiology services (such as radiation treatment for cancer)	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0 Services may require a prior authorization	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0
Hearing services Diagnostic hearing exam Routine hearing exam – TruHearing™ Hearing aid benefit – TruHearing™	You pay \$15 You pay \$45, one routine hearing exam allowed annually \$699/\$999, one aid per ear per year	You pay \$20 You pay \$45, one routine hearing exam allowed annually \$699/\$999, one aid per ear per year

Premiums and Benefits	Forever Blue 68 (PPO) Plan (Class 1B) (2022)	
Dental services Medicare covered dental services Dental allowance	You pay \$0 You pay \$200 annual allowance	You pay \$20 You pay \$200 annual allowance
Vision services Routine eye exam* Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) Annual screening for diabetic retinopathy (for people with diabetes) Eyeglass or contact lenses after cataract surgery* Eyewear allowance* *A Davis Vision provider must be used to be considered in-network	You pay \$15 You pay \$15 You pay \$0 You pay \$0 \$200 annual allowance (INN and OON combined)	You pay \$0 You pay \$20 You pay \$0 You pay \$0 \$200 annual allowance (INN and OON combined)
Mental health services Mental health (inpatient, 190-day lifetime limit) Outpatient group therapy/ individual therapy visit	You pay \$0 per stay You pay \$0 Services may require a prior authorization	You pay \$0 per stay You pay \$0
Skilled nursing facility	You pay \$0 per stay Services may require a prior authorization	You pay \$0 per stay
Physical therapy	You pay \$0	You pay \$0
Ambulance	You pay \$0 Services may require a prior authorization	You pay \$0
Transportation	Not covered	
Medicare Part B drugs Immunosuppressive drugs Oral chemotherapy drugs Physician administered injectables Nebulizer drugs other Part B drugs	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0 Services may require a prior authorization	You pay \$0 You pay \$0 You pay \$0 You pay \$0 You pay \$0

Outpatient Prescription Drugs

Deductible	You pay \$0		
	Preferred Retail Rx 30-day supply	Non-Preferred Retail Rx 30-day supply	Mail Order 90-day supply
Initial coverage			
Tier 1: Preferred generic	You pay \$0	You pay \$5	You pay \$0
Tier 2: Generic	You pay \$5	You pay \$10	You pay \$10
Tier 3: Preferred brand	You pay \$5	You pay \$10	You pay \$10
Tier 4: Non-preferred drug	You pay \$10	You pay \$15	You pay \$20
Tier 5: Specialty tier	You pay \$10	You pay \$15	You pay \$20
Coverage gap or donut hole	No Coverage Gap		
Cost-sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			
Additional Benefits			
Other rehabilitation services			
Occupational therapy	You pay \$0		You pay \$0
Speech therapy	You pay \$0		You pay \$0
Cardiac rehab	You pay \$15		You pay \$20
Chiropractor	You pay \$15		You pay \$20
	Services may require a prior authorization		
Supplies, equipment and devices			
Durable medical equipment	You pay \$0 compression stockings; 20% all other items		You pay 20%
Prosthetics	You pay \$0 diabetic shoes/inserts; 20% all other items		You pay 20%
Diabetic supplies - Part B	You pay \$0		You pay 20%
	Services may require a prior authorization		
Fitness program - Silver Sneakers®	Covered in full		
Hospital observation	You pay \$0		You pay \$0
Dialysis	You pay \$0		You pay Inside service area: 20% for non-participating providers. Outside service area: \$0 for non-participating providers.
Shingles	You pay \$0 Preferred / \$5 Standard		

Additional Benefits

Telemedicine Doctor On Demand® Your health provider	You pay \$0 Your regular copay (Primary = \$15, Specialist = \$15, Mental health professional = \$0, Mental health psychiatrist = \$0, Alcohol & Substance Abuse = \$0)	You pay \$0 Not covered
Home health care	You pay \$0	You pay \$0

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