Medicare Advantage
2027 Benefit Summary

Name: Buffalo Board of Education Medicare
Group Number: 10722575, 10722615, 10722595, 10722635
Effective Date: 1/1/2027

	Forever Blue 799 (PPO) Plan 42	
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)	$3,000	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)	$3,000	
Physician and other Health Professional Services	**In-Network**	**Out-of-Network**
Office Visits - Primary Doctor	$5	$20
Office Visits - Specialist	$15	$20
Radiation Therapy	$15	$20
Emergency Room (waived if admitted within 1 day)	$50	
Urgent Care	$15	
Ambulance (Emergent)	$25	
Ambulance (Non-Emergent)	$25	$25
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)	$0 per stay	20%
Observation Room/Outpatient Surgery (Hospital)	$15	20%
Outpatient Surgery (Ambulatory Center)	$15	20%
Home Health Care	0%	$10
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100	20% 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)	$0 per stay	20%
Mental Health (Outpatient)	$15	20%
Mental Health (Outpatient with Psychiatrist)	$15	20%
Alcohol Substance Abuse (Inpatient)	$0 per stay	20%
Alcohol Substance Abuse (Outpatient)	$15	20%
Laboratory and X-ray Services	**In-Network**	**Out-of-Network**
Laboratory Testing (Physician Office/Free Standing Lab)	$0	$20
Laboratory Testing (Outpatient Facility)	$0	$20
X-rays	$15	$20
Advanced Radiology (MRI, MRA, PET, and CT)	$15	$20
Rehabilitation Services	**In-Network**	**Out-of-Network**
Physical, Occupational, and Speech Therapy	$15	$20
Chiropractor Medicare Covered	$15	$20
Acupuncture & Massage Therapy Annual Allowance	Not Covered	
Cardiac Rehab	$15	$20
Vision	**In-Network**	**Out-of-Network**
Medical Vision Exam	$15	$20

Routine Vision Exam (Offered through Davis Vision)	$15	20%
Annual allowance (lenses and frames) Offered through Davis Vision	$400	
Hearing	**In-Network**	**Out-of-Network**
Diagnostic Hearing Exam	$15	$20
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	$500 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.	$15	$20
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.	$15	$20
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)	$1.00	
Tier 3 (Preferred Brand & Generic)	$7.00	
Tier 4 (Non-Preferred)	$20.00	
Tier 5 (Specialty)	$20.00	
Mail Order Prescription Drugs		
Tier 1 (Preferred Generic)	$0.00	
Tier 2 (Non-Preferred Generic)	$2.00	
Tier 3 (Preferred Brand & Generic)	$14.00	
Tier 4 (Non-Preferred)	$40.00	
Tier 5 (Specialty)	$20.00	
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 27FB042

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