HIGHMARK WESTERN NEW YORK

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

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

GROUP NAME: New York State Employees Medicare

GROUP NUMBER: 10717145

PLAN NAME: Senior Blue 699 (HMO) Plan E (2023)

Physician and other health professional services	In-Network
Primary doctor	$10
Specialist	$30
Radiation therapy	$30
Emergency room (waived if admitted)	$65
Urgent care (waived if admitted)	$35
Ambulance	$100
Telemedicine	Covered in full

More than 20 preventive services	In-Network
Flu shots – Part B	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full
All other preventive screenings and tests	Covered in full

Hospital, home health care, and skilled services	In-Network
Hospital (inpatient)	Covered in full per stay
Observation	$65
Outpatient surgery – hospital	$75
Outpatient surgery – ambulatory center	$75
Home health care	Covered in full
Skilled nursing facility (100 days per benefit period)	Covered in full per stay
Dialysis	Covered in full

Mental health / chemical dependence services	In-Network
Mental health (inpatient, 190-day lifetime limit)	Covered in full per stay
Mental health (outpatient)	$40
Mental health (with psychiatrist)	$40
Alcohol substance abuse (inpatient)	Covered in full per stay
Alcohol substance abuse (outpatient)	$40

Laboratory and X-ray services	In-Network
Laboratory testing	Covered in full
X-rays	$30
Advanced radiology – MRI, MRA, PET, and CT	$30

Rehabilitation services	In-Network
Physical, occupational, and speech therapy	$20
Chiropractor	$20
Acupuncture & Massage Therapy	N/A
Cardiac rehab	$20

Vision	In-Network
Routine vision exam	Covered in full
Medical vision exam	$30
Allowance (lenses and frames)	$200 annual allowance

Hearing	In-Network
Routine hearing exam – TruHearing™	$45
Diagnostic hearing exam	$30
Hearing aid benefit – TruHearing™	$699/$999

Dental	In-Network
Dental	$200 annual allowance

Supplies, equipment, and devices	In-Network
Durable medical equipment	$0 compression stockings; 20% all other items
Prosthetics	$0 diabetic shoes/inserts; 20% all other items
Diabetic supplies – Part B	Covered in full

Fitness program	In-Network
SilverSneakers® (“Steps” program included)	Covered in full

Prescription drugs – Part B	In-Network
Immunosuppressive drugs	Covered in full
Oral chemotherapy drugs	Covered in full
Physician administered injectables	Covered in full
Nebulizer inhalation solution	Covered in full
Part B drugs (other)	Covered in full

Prescription drugs – Part D**	In-Network
Prescription drug (Rx)	$0/$15/$30/$50/$50
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
In-network out-of-pocket maximum	$3,000
Combined out-of-pocket maximum	N/A
Prescription deductible	N/A

****Important Message: If you have prescription cost sharing more than $35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is $35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).**

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请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。