



**Medicare Advantage
2026 Benefit Summary**

Name: New York State (WNY) Employees Medicare

Group Number: 10717145

Effective Date: 1/1/2026

	Senior Blue 699 (HMO) Plan E
Medical Benefits	In-Network
Deductible	\$0
Coinsurance (see specific benefits for cost sharing)	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
Physician and other Health Professional Services	In-Network
Office Visits - Primary Doctor	\$10
Office Visits - Specialist	\$30
Radiation Therapy	\$30
Emergency Room (waived if admitted within 3 days)	\$65
Urgent Care	\$35
Ambulance (Emergent)	\$100
Ambulance (Non-Emergent)	\$100
More than 20 Preventive Services	In-Network
Includes screenings and vaccines such as Flu, Pneumonia, Covid 19, Hepatitis, etc	Covered in Full
Hospital, Home Health Care, and Skilled Services	In-Network
Hospital (Inpatient)	\$0 per stay
Observation Room/Outpatient Surgery (Hospital)	\$75
Outpatient Surgery (Ambulatory Center)	\$75
Home Health Care	0%
Skilled Nursing Facility (100 days per benefit period)	0% days 1-100
Dialysis	\$0
Mental Health/Chemical Dependence Services	In-Network
Mental Health (Inpatient, 190-day lifetime limit)	\$0 per stay
Mental Health (Outpatient)	\$40
Mental Health (Outpatient with Psychiatrist)	\$40
Alcohol Substance Abuse (Inpatient)	\$0 per stay
Alcohol Substance Abuse (Outpatient)	\$40
Laboratory and X-ray Services	In-Network
Laboratory Testing (Physician Office/Free Standing Lab)	\$0
Laboratory Testing (Outpatient Facility)	\$0
X-rays	\$30
Advanced Radiology (MRI, MRA, PET, and CT)	\$30
Rehabilitation Services	In-Network
Physical, Occupational, and Speech Therapy	\$20
Chiropractor Medicare Covered	\$20
Acupuncture & Massage Therapy Annual	Not Covered
Cardiac Rehab	\$20
Vision	In-Network
Medical Vision Exam	\$30
Routine Vision Exam (Offered through Davis Vision)	\$0
Annual allowance (lenses and frames) Offered through Davis Vision	\$200

Hearing	In-Network
Diagnostic Hearing Exam	\$30
Routine Hearing Exam (TruHearing)	\$45
Hearing Aid Benefit (TruHearing)	TruHearing: You pay a \$699 copay for the Advanced or a \$999 copay for the Premium hearing aid. Up to 2 hearing aids per year.
Dental	
Routine Dental	\$200 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
Oxygen	20%
Diabetic Supplies	0%
Fitness Program	In-Network
Highmark Fitness Program	Nationwide Fitness Network
Part B Drugs	In-Network
Immunosuppressive Drugs	0%
Oral Chemotherapy Drugs	0%
Physician Administered Injectables	0%
Nebulizer Inhalation	0%
Part B drugs (other)	0%
Value Added Rider	In-Network
Routine Chiropractic - These are routine/not medically necessary services that are not covered by Original Medicare. Chiropractic visits are limited to 8 visits per calendar year.	Not Covered
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.	\$30
Meal Plan - 1 meal per day up to 7 days upon discharge from an Inpatient Hospital or SNF stay.	Covered
Over the Counter Drug Allowance	Not Covered
Prescription Drugs - Part D	
Prescription Deductible	Not Applicable
True Out of Pocket (TrOOP) Costs Threshold	\$2,100
Formulary	Fundamental
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)	\$15.00
Tier 3 (Preferred Brand & Generic)	\$30.00
Tier 4 (Non-Preferred)	\$50.00
Tier 5 (Specialty)	\$50.00
Mail Order Prescription Drugs	
Tier 1 (Preferred Generic)	\$0.00
Tier 2 (Non-Preferred Generic)	\$30.00
Tier 3 (Preferred Brand & Generic)	\$60.00
Tier 4 (Non-Preferred)	\$100.00
Tier 5 (Specialty)	\$50.00
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 \$2,100, 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 **26SB0E**

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The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

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