1-800-544-2583 bcbswny.com

Benefit Summary for Group:

Effective on or after 1/1/2017

	Platinum Standard		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	200 Network		
Deductible	N/A	$5,000 single / $10,000 family	
Deductible Administration Type	N/A	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	
Coinsurance	N/A	50% coinsurance after deductible	
Out of Pocket Maximum	$2,000 single / $4,000 family	$10,000 single / $20,000 family	
Out of Pocket Administration Type	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	
Benefit Administration Date	Plan year		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$10/$30/$60	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Physician and Other Services			
Primary Office Visit	$15 copayment	50% coinsurance after deductible	
Specialist Office Visit	$35 copayment	50% coinsurance after deductible	
Allergy Testing and Treatment	$15 copayment/$35 copayment	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$15 copayment/$35 copayment	50% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$100 copayment	Covered as in-network	Cost-share waived if admitted
Ambulance	$100 copayment	Covered as in-network	
Urgent Care Center	$55 copayment	$55 copayment after deductible	

Preventive Services			
Bone mineral density Cholesterol Test (lipid panel) Colonoscopy & Sigmoidoscopy Immunizations Mammograms Pap Smear Prenatal and one postpartum visit Prostate Test (Prostate Specific Routine Physical Exam Well Child Visits	Covered in full	50% coinsurance after deductible	Some routine services may not be covered Out-of-network, Please contact Customer Service.
Hospital Services			
Inpatient Hospital	$500 copayment	50% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$100 copayment	50% coinsurance after deductible	
Skilled Nursing Facility	$500 copayment	50% coinsurance after deductible	200 days per year
Diagnostic Testing Services			
Laboratory Tests	$35 copayment	50% coinsurance after deductible	
Radiology	$35 copayment	50% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$15 copayment	50% coinsurance after deductible	
Inpatient Maternity	$500 copayment	50% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$500 copayment	50% coinsurance after deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	$15 copayment	50% coinsurance after deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	$500 copayment	50% coinsurance after deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	$500 copayment	50% coinsurance after deductible	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	$15 copayment	50% coinsurance after deductible	Unlimited visits, up to 20 visits a year may be used for family counseling; subject to medical necessity.
Diabetic Supplies and Services			
Diabetic Equipment	$15 copayment	50% coinsurance after deductible	
Insulin and Other Oral Agents	$15 copayment	50% coinsurance after deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. Diabetic drugs rendered at pharmacy are only covered in-network.
Diabetic Medical Supplies (Test strips, Syringes, ect)	$15 copayment	50% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$35 copayment	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment	50% coinsurance after deductible	60 visits per condition per plan year

Pulmonary Rehabilitation	$15 copayment	50% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	10% coinsurance	50% coinsurance after deductible	
Prosthetics and Appliances	10% coinsurance	50% coinsurance after deductible	Shoe orthotics not covered.
Home Health Care	$15 copayment	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	$15 copayment	50% coinsurance after deductible	210 days per year
Chemotherapy - Outpatient Facility	$15 copayment	50% coinsurance after deductible	
Dialysis	$15 copayment	50% coinsurance after deductible	
Wellness Card	$250 per contract	N/A	Benefit allowance accessible through use of debit card at participating providers for gym membership, massage, acupuncture, health food stores, chiropractic visits, etc
Pediatric Vision Services			
Routine Exam	Covered in full	50% coinsurance after deductible	One Routine exam covered in full every other year, coverage up to Age 19
Medical Eye Exam	$15 copayment	50% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	50% coinsurance after deductible	One exam every year
Medical Eye Exam	$15 copayment	50% coinsurance after deductible	
Dental Services			
Pediatric Dental	$19.14 premium per child		Pediatric Dental is a Essential Health Benefit required for dependents under age 19. Coverage will be offered to your employees, and if elected, will appear on your premium invoice. You will be responsible to collect the premium.

*For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

**This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply