BlueShield of Northeastern New York
30 Century Hill Drive • Latham, New York 12110
1-800-888-1238 bsneny.com

Benefit Summary for Group:

Effective Date: On or after 1/1/2016

	2016 Bronze Value		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	POS		
Deductible	$6,450 single / $12,900 family	$6,450 single / $12,900 family	Embedded
First Dollar Coverage	N/A	Not Covered	
Coinsurance	0% after deductible	0% after deductible	
Out of Pocket Maximum	$6,450 single / $12,900 family	$6,450 single / $12,900 family	Embedded
Deductible and Out of Pocket Administration Type	Embedded	Embedded	On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.
Benefit Administration	Plan year	Plan year	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and Sigmoidoscopy Contraceptive drugs, Devices and Counseling Immunizations Mammogram Pap smear Prostate test (Prostate Specific Antigen "PSA") Routine physical exam Prenatal and one postpartum visit Well child visit Well woman visit	Covered in full	0% coinsurance after Deductible	Some routine services may not be covered Out-of-Network. Please contact Customer Service.
Physician and Other Services			
Primary Office Visit	0% coinsurance after deductible	0% coinsurance after Deductible	
Specialist Office Visit	0% coinsurance after deductible	0% coinsurance after Deductible	
Allergy Testing and Treatment	0% coinsurance after deductible	0% coinsurance after Deductible	
Outpatient Surgical Procedures (in physician's office)	0% coinsurance after deductible	0% coinsurance after Deductible	

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Emergency and Urgent Care Services			
Emergency Room	0% after deductible	0% after deductible	
Ambulance	0% after deductible	0% after deductible	
Urgent Care	0% after deductible	0% after deductible	
Hospital Services			
Inpatient Hospital	0% after deductible	0% coinsurance after Deductible	
Outpatient Surgical Procedures (facility)	0% after deductible	0% coinsurance after Deductible	
Skilled Nursing Facility	0% after deductible	0% coinsurance after Deductible	Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	0% after deductible	0% coinsurance after Deductible	
Radiology	0% after deductible	0% coinsurance after Deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	0% after deductible	0% coinsurance after Deductible	
Inpatient Maternity	0% after deductible	0% coinsurance after Deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	0% after deductible	0% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	0% after deductible	0% coinsurance after Deductible	Unlimited visits, subject to medical necessity.
Inpatient Substance Abuse - Rehab	0% after deductible	0% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	0% after deductible	0% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	0% after deductible	0% coinsurance after Deductible	Unlimited visits, up to 20 visits a year may be used for family counseling; subject to medical necessity.

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Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	0% after deductible	0% coinsurance after Deductible	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	0% after deductible	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	0% after deductible	0% coinsurance after Deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	0% after deductible	0% coinsurance after Deductible	
Physical - Occupational - Speech Therapies	0% after deductible	0% coinsurance after Deductible	60 combined rehabilitative PT/OT/ST visits per member, per year
Pulmonary Rehabilitation	0% after deductible	0% coinsurance after Deductible	
Additional Services			
Durable Medical Equipment	0% after deductible	0% coinsurance after Deductible	
Prosthetics and Appliances	0% after deductible	0% coinsurance after Deductible	
Chemotherapy - Outpatient Facility	0% after deductible	0% coinsurance after Deductible	
Hospice	0% after deductible	0% coinsurance after Deductible	210 days per plan year
Home Health Care	0% after deductible	0% coinsurance after Deductible	40 aggregate visits per plan year; includes home infusion.
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.
Prescription Drug Coverage			
Prescription Drug	0% after deductible	Not Covered	

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Prescription Drug Coverage			
Mail Order	2.5 copay - 90 day supply after deductible	Not Covered	
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	0% after deductible	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	0% after deductible	0% coinsurance after Deductible	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	0% after deductible	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	0% coinsurance after Deductible	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	0% coinsurance after Deductible	0% coinsurance after Deductible	
Standard Plastic Lenses	discounts available	Not Covered	
Frames	discounts available	Not Covered	
Conventional Contact Lenses	discounts available	Not Covered	
Laser Vision Correction	discounts available	Not Covered	
Dental Services			
*Pediatric Dental - see statement below	$22.09 premium per child		
Dependent Coverage			
Dependent age	26	26	
Domestic partner and children	Covered	Covered	

This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.
*PEDIATRIC DENTAL IS AN 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.