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 Gold EPO 5000		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO		
Deductible	$500 single / $1,000 family	Not Covered	Embedded
First Dollar Coverage	N/A	N/A	
Coinsurance	20%	Not Covered	
Out of Pocket Maximum	$3,500 single/ $7,000 family	Not Covered	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	Not Covered	
Physician and Other Services			
Primary Office Visit	$30 copay	Not Covered	$0 pediatric PCP visits
Specialist Office Visit	$50 copay	Not Covered	
Allergy Testing and Treatment	PCP/Specialist Copay	Not Covered	Copay based on where service is rendered
Outpatient Surgical Procedures (in physician's office)	PCP/Specialist Copay	Not Covered	Copay based on where service is rendered
Emergency and Urgent Care Services			
Emergency Room	$150 copay	$150 copay	Cost-share waived if admitted.

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Emergency and Urgent Care Services			
Ambulance	$150 copay	$150 copay	
Urgent Care	$100 copay	$100 copay	
Hospital Services			
Inpatient Hospital	20% Coinsurance after Deductible per admission	Not Covered	
Outpatient Surgical Procedures (facility)	20% coinsurance after deductible	Not Covered	
Skilled Nursing Facility	20% Coinsurance after Deductible per admission	Not Covered	Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	$30 copay	Not Covered	
Radiology	20% coinsurance after deductible	Not Covered	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$30 copay	Not Covered	Cost-share to initial visit for physician fee for maternity care; additional services will take a cost-share as required.
Inpatient Maternity	20% Coinsurance after Deductible per admission	Not Covered	Cost-share does not apply to newborn.
Mental Health and Substance Abuse			
Inpatient Mental Health	20% Coinsurance after Deductible per admission	Not Covered	Unlimited visits, subject to medical necessity
Outpatient Mental Health	$0 copay	Not Covered	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	20% Coinsurance after Deductible per admission	Not Covered	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	20% Coinsurance after Deductible per admission	Not Covered	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	$0 copay	Not Covered	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.)	$30 copay	Not Covered	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	$30 copay	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$30 copay	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	$30 copay	Not Covered	
Physical - Occupational - Speech Therapies	$30 copay	Not Covered	60 combined rehabilitative PT/OT/ST visits per person, per year
Pulmonary Rehabilitation	20% coinsurance after deductible	Not Covered	
Additional Services			
Durable Medical Equipment	20% coinsurance after deductible	Not Covered	
Prosthetics and Appliances	20% coinsurance after deductible	Not Covered	
Chemotherapy - Outpatient Facility	20% coinsurance after deductible	Not Covered	
Hospice	20% coinsurance after deductible	Not Covered	210 days per plan year
Home Health Care	$50 copay	Not Covered	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	$10/$35/$70 copay	Not Covered	
Mail Order	2.5 copay - 90 day supply	Not Covered	

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Prescription Drug Coverage			
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	$50 copay	Not Covered	One routine exam covered in full every other year
Medical Eye Exam	$50 copay	Not Covered	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	20% coinsurance after deductible	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	$50 copay	Not Covered	One routine exam covered in full every other year
Medical Eye Exam	$50 copay	Not Covered	
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.