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 Platinum Radius		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	200		
Deductible	N/A	$250 single / $500 family	Embedded
First Dollar Coverage	N/A	Not Covered	
Coinsurance	N/A	20%	
Out of Pocket Maximum	$6,600 single / $13,200 family	$10,000 single / $20,000 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	20% coinsurance after deductible	Some routine services may not be covered Out-of-Network. Please contact Customer Service.
Physician and Other Services			
Primary Office Visit	$25 copay	20% coinsurance after deductible	$0 pediatric PCP visits and $0 for first three adult PCP visits
Specialist Office Visit	$40 copay	20% coinsurance after deductible	
Allergy Testing and Treatment	PCP/Specialist Copay	20% coinsurance after deductible	Copay based on where service is rendered
Outpatient Surgical Procedures (in physician's office)	PCP/Specialist Copay	20% coinsurance after deductible	Copay based on where service is rendered

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Emergency and Urgent Care Services			
Emergency Room	$200 copay	$200 copay	Cost-share waived if admitted.
Ambulance	$200 copay	$200 copay	
Urgent Care	$75 copay	$75 copay after deductible	
Hospital Services			
Inpatient Hospital	$750 copay per admission	20% coinsurance after deductible	
Outpatient Surgical Procedures (facility)	$200 copay	20% coinsurance after deductible	
Skilled Nursing Facility	$750 copay per admission	20% coinsurance after deductible	Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	$25 copay	20% coinsurance after deductible	
Radiology	$40 copay	20% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$25 copay	20% coinsurance after deductible	
Inpatient Maternity	$750 copay per admission	20% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$750 copay per admission	20% coinsurance after deductible	Unlimited visits, subject to medical necessity.
Outpatient Mental Health	$40 copay	20% coinsurance after deductible	Unlimited visits, subject to medical necessity.
Inpatient Substance Abuse - Rehab	$750 copay per admission	20% coinsurance after deductible	Unlimited visits, subject to medical necessity.
Inpatient Substance Abuse - Detox	$750 copay per admission	20% coinsurance after deductible	Unlimited visits, subject to medical necessity.
Outpatient Substance Abuse	$40 copay	20% 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.)	$25 copay	20% coinsurance after deductible	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	$25 copay	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$25 copay	20% coinsurance after deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	$25 copay	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copay	20% coinsurance after deductible	60 combined rehabilitative PT/OT/ST visits per member per plan year
Pulmonary Rehabilitation	$40 copay	20% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	50% Coinsurance	50% coinsurance after Deductible	
Prosthetics and Appliances	50% Coinsurance	50% coinsurance after Deductible	One prosthetic device, per limb, per lifetime (standard equipment only); For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Chemotherapy - Outpatient Facility	$40 copay	20% coinsurance after deductible	
Hospice	$40 copay	20% coinsurance after deductible	210 days per plan year
Home Health Care	$40 copay	20% coinsurance after deductible	40 aggregate visits per plan year; includes home infusion.

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Additional Services			
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	$4/$35/$70 copay	Not Covered	
Mail Order	2.5 copay - 90 day supply	Not Covered	
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	$40 copay	Not Covered	One exam covered in full every other year
Medical Eye Exam	$40 copay	20% coinsurance after deductible	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	10% Coinsurance	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	$40 copay	Not Covered	One exam covered in full every other year
Medical Eye Exam	$40 copay	20% 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.