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 Silver EPO 8000 b		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO		
Deductible	$3,000 single / $6,000 family	Not Covered	Embedded
First Dollar Coverage	N/A	Not Covered	
Coinsurance	0% after deductible	Not Covered	
Out of Pocket Maximum	$6,550 single / $13,100 family	Not Covered	Embedded
Deductible and Out of Pocket Administration Type	Embedded	N/A	On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.
Benefit Administration	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	Covered in full after deductible	Not Covered	
Specialist Office Visit	Covered in full after deductible	Not Covered	
Allergy Testing and Treatment	Covered in full after deductible	Not Covered	
Outpatient Surgical Procedures (in physician's office)	Covered in full after deductible	Not Covered	
Emergency and Urgent Care Services			
Emergency Room	Covered in full after deductible	Covered as in-network	Cost-share waived if admitted.

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Emergency and Urgent Care Services			
Ambulance	Covered in full after deductible	Covered as in-network	
Urgent Care	Covered in full after deductible	Covered in full after in-network deductible	
Hospital Services			
Inpatient Hospital	Covered in full after deductible	Not Covered	
Outpatient Surgical Procedures (facility)	Covered in full after deductible	Not Covered	
Skilled Nursing Facility	Covered in full after deductible	Not Covered	Unlimited days per year
Diagnostic Testing Services			
Laboratory Testing	Covered in full after deductible	Not Covered	
Radiology	Covered in full after deductible	Not Covered	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	Covered in full after deductible	Not Covered	Cost-share to initial visit for physician fee for maternity care; additional services will take a cost-share as required.
Inpatient Maternity	Covered in full after deductible	Not Covered	Cost-share does not apply to newborn.
Mental Health and Substance Abuse			
Inpatient Mental Health	Covered in full after deductible	Not Covered	Unlimited visits, subject to medical necessity
Outpatient Mental Health	Covered in full after deductible	Not Covered	Unlimited visits, subject to medical necessity.
Inpatient Substance Abuse - Rehab	Covered in full after deductible	Not Covered	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	Covered in full after deductible	Not Covered	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	Covered in full after deductible	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.)	Covered in full after deductible	Not Covered	Diabetic equipment must be purchased at a DME Provider. Diabetic equipment is not covered and/or processed through our pharmacy vendor.
Insulin and Other Oral Agents	Covered in full 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.)	Covered in full after deductible	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	Covered in full after deductible	Not CoveredNot Covered	
Physical - Occupational - Speech Therapies	Covered in full after deductible	Not Covered	60 combined rehabilitative PT/OT/ST visits per condition, per lifetime
Pulmonary Rehabilitation	Covered in full after deductible	Not Covered	
Additional Services			
Durable Medical Equipment	Covered in full after deductible	Not Covered	
Prosthetics and Appliances	Covered in full after deductible	Not Covered	
Chemotherapy - Outpatient Facility	Covered in full after deductible	Not Covered	
Hospice	Covered in full after deductible	Not Covered	210 days per plan year
Home Health Care	Covered in full after deductible	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	$4/$35/$70 after deductible	Not Covered	
Mail Order	2.5 copay - 90 day supply after deductible	Not Covered	

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Prescription Drug Coverage			
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	Covered in full after deductible	Not Covered	One routine exam covered in full every other year
Medical Eye Exam	Covered in full after deductible	Not Covered	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	30% coinsurance after deductible	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	Covered in full after deductible	Not Covered	One routine exam covered in full every other year
Medical Eye Exam	Covered in full after deductible	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.