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 Sliver Standard		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	POS		
Deductible	$2,000 single / $4,000 family	$5,000 single / $10,000 family	Embedded
First Dollar Coverage	N/A	N/A	
Coinsurance	N/A	50% after deductible	
Out of Pocket Maximum	$5,500 single / $11,000 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 Routine physical exam Prenatal and one postpartum visit Well child visit Well woman visit	Covered in full	50% coinsurance after Deductible	Some routine services may not be covered Out-of-Network. Please contact Customer Service.
Physician and Other Services			
Primary Office Visit	$30 copay after deductible	50% coinsurance after Deductible	
Specialist Office Visit	$50 copay after deductible	50% coinsurance after Deductible	
Allergy Testing and Treatment	PCP/Specialist Copay after Deductible	50% coinsurance after Deductible	Copay based on where service is rendered
Outpatient Surgical Procedures (in physician's office)	PCP/Specialist Copay after Deductible	50% coinsurance after Deductible	Copay based on where service is rendered
Emergency and Urgent Care Services			
Emergency Room	$150 copay after deductible	$150 copay after deductible	Cost-share waived if admitted.

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Emergency and Urgent Care Services			
Ambulance	$150 copay after deductible	$150 copay after deductible	
Urgent Care	$70 copay after deductible	$70 copay after deductible	
Hospital Services			
Inpatient Hospital	$1,500 copay after deductible per admission	50% coinsurance per admission after deductible	
Outpatient Surgical Procedures (facility)	$100 copay after deductible	50% coinsurance after Deductible	
Skilled Nursing Facility	$1,500 copay after deductible per admission	50% coinsurance per admission after deductible	200 days per plan year
Diagnostic Testing Services			
Laboratory Testing	$50 copay after deductible	50% coinsurance after Deductible	
Radiology	$50 copay after deductible	50% coinsurance after Deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$30 copay after deductible	50% coinsurance after Deductible	
Inpatient Maternity	$1,500 copay per admission after deductible	50% coinsurance per admission after deductible	Cost-share does not apply to newborn.
Mental Health and Substance Abuse			
Inpatient Mental Health	$1,500 copay after deductible per admission	50% coinsurance per admission after deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	$30 copay after deductible	50% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	$1,500 copay after deductible per admission	50% coinsurance per admission after deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	$1,500 copay after deductible per admission	50% coinsurance per admission after deductible	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	$30 copay after deductible	50% 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.)	$30 copay after deductible	50% coinsurance after Deductible	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	$30 copay 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.)	$30 copay after deductible	50% coinsurance after Deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	$50 copay after deductible	50% coinsurance after Deductible	
Physical - Occupational - Speech Therapies	$30 copay after deductible	50% coinsurance after Deductible	60 combined rehabilitative PT/OT/ST visits per condition, per lifetime
Pulmonary Rehabilitation	$30 copay after deductible	50% coinsurance after Deductible	
Additional Services			
Durable Medical Equipment	30% coinsurance after deductible	50% coinsurance after Deductible	
Prosthetics and Appliances	30% coinsurance after deductible	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	$30 copay after deductible	50% coinsurance after Deductible	
Hospice	$30 copay after deductible	50% coinsurance after Deductible	210 days per plan year
Home Health Care	$30 copay after deductible	50% 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	$10/$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	$30 copay after deductible	Not Covered	One exam covered in full every other year
Medical Eye Exam	$30 copay after deductible	50% coinsurance after Deductible	
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	$30 copay after deductible	Not Covered	One exam covered in full every other year
Medical Eye Exam	$30 copay 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.