BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary:

Effective on or after 1/1/2018

	NENY Gold Radius (2018)		
	In-Network	**Out-of-Network**	**Additional Information**
General Information			
Provider Network	200 Plus Network		
Deductible	$500 single / $1,000 family	$500 single / $1,000 family	
Deductible Administration Type	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	
Coinsurance	20% coinsurance after deductible	20% coinsurance after deductible	
Out of Pocket Maximum	$7,200 single /$14,400 family	$7,200 single /$14,400 family	
Out of Pocket Administration Type	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	
Benefit Administration Date	Plan year		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$4/$35/$70 not subject to deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Prescription Deductible	No		

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Physician and Other Services			
Primary Office Visit	$25 copayment not subject to deductible	20% coinsurance after deductible	All PCP visits for <19 at the $0 cost-share not subject to deductible
Specialist Office Visit	$50 copayment not subject to deductible	20% coinsurance after deductible	
Allergy Testing and Treatment	$25 copayment/$50 copayment not subject to deductible	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$50 copayment not subject to deductible	20% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$200 copayment not subject to deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	$200 copayment not subject to deductible	Covered as in-network	
Urgent Care Center	$100 copayment not subject to deductible	$100 copayment after deductible	
Preventive Services			
Bone mineral density measurement or test Cholesterol Test (lipid panel) Colonoscopy & Sigmoidoscopy Immunizations Prostate Test (Prostate Specific Antigen "PSA") Routine Physical Exam Well Child Visits	Covered in full not subject to deductible	20% coinsurance after deductible	Some routine services may not be covered Out-of-network, Please contact Customer Service.
Hospital Services			
Inpatient Hospital	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	20% coinsurance after deductible	20% coinsurance after deductible	
Skilled Nursing Facility	20% coinsurance after deductible	20% coinsurance after deductible	
Diagnostic Testing Services			
Laboratory Tests	$25 copayment not subject to deductible	20% coinsurance after deductible	
Radiology	20% coinsurance after deductible	20% coinsurance after deductible	

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Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment not subject to deductible	20% coinsurance after deductible	
Inpatient Maternity	20% coinsurance after deductible	20% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient Mental Health	Covered in full not subject to deductible	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	20% coinsurance after deductible	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	20% coinsurance after deductible	20% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full not subject to deductible	20% coinsurance after deductible	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services			
Diabetic Equipment	$25 copayment not subject to deductible	20% coinsurance after deductible	
Insulin and Other Oral Agents	$25 copayment not subject to deductible	20% coinsurance after deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. Diabetic drugs rendered at pharmacy are only covered in-network.
Diabetic Medical Supplies (Test strips, Syringes, etc)	$25 copayment not subject to deductible	20% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$25 copayment not subject to deductible	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment not subject to deductible	20% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	20% coinsurance after deductible	20% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible	
Prosthetics and Appliances	20% coinsurance after deductible	20% coinsurance after deductible	Shoe orthotics not covered. For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Home Health Care	$50 copayment not subject to deductible	20% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.

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Additional Services			
Hospice	20% coinsurance after deductible	20% coinsurance after deductible	210 days per year
Chemotherapy - Outpatient Facility	20% coinsurance after deductible	20% coinsurance after deductible	
Dialysis	$50 copayment not subject to deductible	20% coinsurance after deductible	
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
Pediatric Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	One routine exam covered in full every year, coverage up to Age 19
Medical Eye Exam	$50 copayment not subject to deductible	20% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	One exam every year
Medical Eye Exam	$50 copayment not subject to deductible	20% coinsurance after deductible	
Dental Services			
Pediatric Dental	$21.41 premium per child		Pediatric Dental is a 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.

*For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

**This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply