1-800-544-2583 **bcbswny.com**

Benefit Summary:

Effective on or after 1/1/2017

	Silver PPO 8100		
	In-Network	**Out-of-Network**	**Additional Information**
General Information			
Provider Network	PPO		
Deductible	$2,000 single / $4,000 family	$2,000 single / $4,000 family	
Deductible Administration Type	True Family - any individual within a family may be held responsible for the entire family amount	True Family - any individual within a family may be held responsible for the entire family amount	
Coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	
Out of Pocket Maximum	$5,500 single/ $11.000 family	$10,000 single / $20,000 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	$5/$30/50% after deductible	Not covered	
Mail Order	2.5 copays per 90 day supply	Not covered	
Physician and Other Services			
Primary Office Visit	20% coinsurance after deductible	40% coinsurance after deductible	
Specialist Office Visit	20% coinsurance after deductible	40% coinsurance after deductible	
Allergy Testing and Treatment	20% coinsurance after deductible	40% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	20% coinsurance after deductible	40% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	Cost-share waived if admitted
Ambulance	20% coinsurance after deductible	20% coinsurance after deductible	
Urgent Care Center	20% coinsurance after deductible	20% coinsurance after deductible	

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	Silver PPO 8100		
	In-Network	Out-of-Network	Additional Information
Preventive Services			
Bone mineral density measurement or test Cholesterol Test (lipid panel) Colonoscopy & Sigmoidoscopy Immunizations Mammograms Pap Smear Prenatal and one postpartum visit Prostate Test (Prostate Specific Antigen "PSA") Routine Physical Exam Well Child Visits	Covered in full	40% coinsurance after deductible	Some routine services may not be covered Out-of-network, Please contact Customer Service.
Hospital Services			
Inpatient Hospital	$750 copayment after deductible	40% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	20% coinsurance after deductible	40% coinsurance after deductible	
Skilled Nursing Facility	$750 copayment after deductible	40% coinsurance after deductible	Unlimited days per year
Diagnostic Testing Services			
Laboratory Tests	20% coinsurance after deductible	40% coinsurance after deductible	
Radiology	20% coinsurance after deductible	40% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	20% coinsurance after deductible	40% coinsurance after deductible	
Inpatient Maternity	$750 copayment after deductible	40% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$750 copayment after deductible	40% coinsurance after deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	20% coinsurance after deductible	40% coinsurance after deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	$750 copayment after deductible	40% coinsurance after deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	$750 copayment after deductible	40% coinsurance after deductible	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	20% coinsurance after deductible	40% 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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	In-Network	Out-of-Network	Additional Information
Diabetic Supplies and Services			
Diabetic Equipment	20% coinsurance after deductible	40% coinsurance after deductible	
Insulin and Other Oral Agents	20% coinsurance after deductible	40% 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)	20% coinsurance after deductible	40% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	20% coinsurance after deductible	40% coinsurance after deductible	
Physical - Occupational - Speech Therapies	20% coinsurance after deductible	40% coinsurance after deductible	60 combined rehabilitative PT/OT/ST outpatient visits per person, per plan year
Pulmonary Rehabilitation	20% coinsurance after deductible	40% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	20% coinsurance after deductible	40% coinsurance after deductible	
Prosthetics and Appliances	20% coinsurance after deductible	40% coinsurance after deductible	Shoe orthotics not covered.
Home Health Care	20% coinsurance after deductible	40% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	20% coinsurance after deductible	40% coinsurance after deductible	210 days per year
Chemotherapy - Outpatient Facility	20% coinsurance after deductible	40% coinsurance after deductible	
Dialysis	20% coinsurance after deductible	40% 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	20% coinsurance after deductible	Not covered	One exam per 12 month period; One routine exam covered in full every other year, off-year follows cost share, coverage up to age 19

Benefit Summary:

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	Silver PPO 8100		
	In-Network	Out-of-Network	Additional Information
Medical Eye Exam	20% coinsurance after deductible	40% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	One exam every year
Medical Eye Exam	20% coinsurance after deductible	40% coinsurance after deductible	
Dental Services			
Pediatric Dental	$19.14 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