



1-800-544-2583

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**Benefit Summary:  
Effective on or after 1/1/2019**

	WNY Silver PPO 8100 (2019)		
	In-Network	Out-of-Network	Additional Information
<b>General Information</b>			
Provider Network	PPO		
Deductible	\$2,900 single / \$5,800 family	\$5,000 single / \$10,000 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	35% coinsurance after deductible	50% coinsurance after deductible	
Out of Pocket Maximum	\$6,650 single / \$13,300 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		
<b>Dependent Coverage</b>			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Covered		
<b>Prescription Drug Coverage</b>			
Prescription Drugs	\$5/\$30/50% after deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx subject to Medical Deductible?	Yes		

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<b>Physician and Other Services</b>			
Primary Office Visit	35% coinsurance after deductible	50% coinsurance after deductible	
Specialist Office Visit	35% coinsurance after deductible	50% coinsurance after deductible	
Allergy Injections	35% coinsurance after deductible	50% coinsurance after deductible	
Allergy Testing	35% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	35% coinsurance after deductible	50% coinsurance after deductible	
<b>Emergency and Urgent Care Services</b>			
Emergency Room	35% coinsurance after deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	35% coinsurance after deductible	Covered as in-network	
Urgent Care Center	35% coinsurance after deductible	35% coinsurance after deductible	
<b>Preventive Services</b>			
Bone mineral density measurement or test	Covered in full not subject to deductible	50% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	50% coinsurance after deductible	
Immunizations	Covered in full not subject to deductible	50% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	50% coinsurance after deductible	
Routine Physical Exam	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	50% coinsurance after deductible	
<b>Hospital Services</b>			
Inpatient Hospital	\$1,000 copayment after deductible	50% coinsurance after deductible	

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<b>Hospital Services</b>			
Outpatient Surgical Procedure (Facility)	35% coinsurance after deductible	50% coinsurance after deductible	
Skilled Nursing Facility	\$1,000 copayment after deductible	50% coinsurance after deductible	
<b>Diagnostic Testing Services</b>			
Laboratory Tests	35% coinsurance after deductible	50% coinsurance after deductible	
Radiology	35% coinsurance after deductible	50% coinsurance after deductible	
<b>Maternity Services</b>			
Physician Services: Prenatal and Postnatal Care (initial visit)	35% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Maternity	\$1,000 copayment after deductible	50% coinsurance after deductible	
<b>Mental Health and Substance Abuse</b>			
Inpatient Mental Health	\$1,000 copayment after deductible	50% coinsurance after deductible	
Outpatient Mental Health	35% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	\$1,000 copayment after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Detox	\$1,000 copayment after deductible	50% coinsurance after deductible	
Outpatient Substance Abuse	35% coinsurance after deductible	50% coinsurance after deductible	Up to 20 visits a year may be used for family counseling
<b>Diabetic Supplies and Services</b>			
Diabetic Equipment	35% coinsurance after deductible	50% coinsurance after deductible	
Insulin and Other Oral Agents	35% coinsurance after deductible	50% 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)	35% coinsurance after deductible	50% coinsurance after deductible	
<b>Rehabilitation Services</b>			
Chiropractic Care	35% coinsurance after deductible	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	35% coinsurance after deductible	50% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	35% coinsurance after deductible	50% coinsurance after deductible	

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<b>Additional Services</b>			
Durable Medical Equipment	35% coinsurance after deductible	50% coinsurance after deductible	
Prosthetics and Appliances	35% coinsurance after deductible	50% 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	35% coinsurance after deductible	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	35% coinsurance after deductible	50% coinsurance after deductible	210 days per year
Chemotherapy - Outpatient Facility	35% coinsurance after deductible	50% coinsurance after deductible	
Dialysis	35% coinsurance after deductible	50% 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
<b>Pediatric Vision Services</b>			
Routine Exam	Covered in full not subject to deductible	Not covered	One routine exam every year, coverage up to Age 19
Medical Eye Exam	35% coinsurance after deductible	50% coinsurance after deductible	
<b>Adult Vision Services</b>			
Routine Exam	Covered in full not subject to deductible	Not covered	One exam every year
Medical Eye Exam	35% coinsurance after deductible	50% coinsurance after deductible	

\*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