BlueCross BlueShield of Western New York
257 West Genesee Street • Buffalo, New York 14202
1-800-544-2583 bcbswny.com

Benefit Summary:

Effective Date: For plans effective on or after 1/1/16

	2016 Platinum HMO 110 Plus		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	100		
Deductible	N/A	$1,500 single / $3,000 family	Embedded
First Dollar Coverage	N/A	Not Covered	
Coinsurance	N/A	40% after deductible	
Out of Pocket Maximum	$4,000 single / $8,000 family	$4,000 single / $8,000 family	Embedded
Deductible and Out of Pocket Administration Type	Embedded	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 Prostate test (Prostate Specific Antigen "PSA") Routine physical exam Prenatal and one postpartum visit Well child visit Well woman visit	Covered in full	40% coinsurance after Deductible	Some routine services may not be covered Out-of-Network. Please contact Customer Service.
Physician and Other Services			
Primary Office Visit	$20 copay	40% coinsurance after Deductible	
Specialist Office Visit	$30 copay	40% coinsurance after Deductible	
Allergy Testing and Treatment	PCP/Specialist Copay	40% coinsurance after Deductible	Copay based on where service is rendered
Outpatient Surgical Procedures (in physician's office)	PCP/Specialist Copay	40% coinsurance after Deductible	Copay based on where service is rendered

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Emergency and Urgent Care Services			
Emergency Room	$100 copay	$100 copay	Cost-share waived if admitted.
Ambulance	$100 copay	$100 copay	
Urgent Care	$40 copay	$40 copay	
Hospital Services			
Inpatient Hospital	$500 copay per admission	40% coinsurance after Deductible	
Outpatient Surgical Procedures (facility)	$150 copay	40% coinsurance after Deductible	
Skilled Nursing Facility	$500 copay per admission	40% coinsurance after Deductible	Unlimited days per plan year.
Diagnostic Testing Services			
Laboratory Testing	Covered In Full	40% coinsurance after Deductible	
Radiology	$30 copay	40% coinsurance after Deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$20 copay	40% coinsurance after Deductible	
Inpatient Maternity	$500 copay per admission	40% coinsurance after Deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$500 copay per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Outpatient Mental Health	$30 copay	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Rehab	$500 copay per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Inpatient Substance Abuse - Detox	$500 copay per admission	40% coinsurance after Deductible	Unlimited visits, subject to medical necessity
Outpatient Substance Abuse	$30 copay	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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Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$20 copay	40% coinsurance after Deductible	Diabetic equipment rendered at pharmacy will be covered as a medical benefit.
Insulin and Other Oral Agents	$20 copay	Not Covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$20 copay	40% coinsurance after Deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit.
Rehabilitation Services			
Chiropractic Care	$20 copay	40% coinsurance after Deductible	
Physical - Occupational - Speech Therapies	$20 copay	40% coinsurance after Deductible	60 combined habilitative PT/OT/ST outpatient visits per person, per plan year.
Pulmonary Rehabilitation	$30 copay	40% coinsurance after Deductible	
Additional Services			
Durable Medical Equipment	50% Coinsurance	50% coinsurance after Deductible	
Prosthetics and Appliances	50% Coinsurance	50% coinsurance after Deductible	
Chemotherapy - Outpatient Facility	$30 copay	40% coinsurance after Deductible	
Hospice	$30 copay	40% coinsurance after Deductible	210 days per plan year
Home Health Care	$30 copay	40% coinsurance after Deductible	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	$5/$30/50%	Not Covered	
Mail Order	2.5 copay - 90 day supply	Not Covered	

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Prescription Drug Coverage			
Medicare Part D Creditable Coverage Status	Yes	N/A	
Pediatric Vision Services			
Routine Exam	$30 copay	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	$30 copay	40% coinsurance after Deductible	
Standard Plastic Lenses, Frames and Conventional Contact Lenses	10% Coinsurance	Not Covered	Cover standard frames/lenses OR contact lenses every 12 months
Adult Vision Services			
Routine Exam	$30 copay	Not Covered	One routine eye exam covered in full every other year
Medical Eye Exam	$30 copay	40% coinsurance after Deductible	
Standard Plastic Lenses	$50 allowance	Not Covered	
Frames	40% off retail price	Not Covered	
Conventional Contact Lenses	15% off retail price	Not Covered	
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Dental Services			
*Pediatric Dental - see statement below	$18.21 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.