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 PPO 843 | | |
|---|---|---|---|
| | In-Network | Out-of-Network | Additional Information |
| **General Information** | | | |
| Provider Network | PPO | | |
| Deductible | $500 single / $1,000 family | $500 single / $1,000 family | Embedded |
| First Dollar Coverage | N/A | Not Covered | |
| Coinsurance | 20% after deductible | 40% after deductible | |
| Out of Pocket Maximum | $1,000 single / $2,000 family | $5,000 single / $10,000 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<br>Cholesterol test (lipid panel)<br>Colonoscopy and Sigmoidoscopy<br>Contraceptive drugs, Devices and Counseling<br>Immunizations<br>Mammogram<br>Pap smear<br>Prostate test (Prostate Specific Antigen "PSA")<br>Routine physical exam<br>Prenatal and one postpartum visit<br>Well child visit<br>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% 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 | |

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| **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 | 20% coinsurance after deductible | 20% coinsurance after deductible | |
| **Hospital Services** | | | |
| Inpatient Hospital | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| Outpatient Surgical Procedures (facility) | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| Skilled Nursing Facility | 20% coinsurance after deductible | 40% coinsurance after Deductible | Unlimited days per plan year |
| **Diagnostic Testing Services** | | | |
| Laboratory Testing | 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 | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| Inpatient Maternity | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| **Mental Health and Substance Abuse** | | | |
| Inpatient Mental Health | 20% coinsurance 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 | 20% coinsurance after deductible | 40% coinsurance after Deductible | Unlimited visits, subject to medical necessity |
| Inpatient Substance Abuse - Detox | 20% coinsurance 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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| **Diabetic Supplies and Services** | | | |
| Diabetic Equipment (e.g. Blood glucose monitor, etc.) | 20% coinsurance after deductible | 40% coinsurance after Deductible | Diabetic equipment rendered at pharmacy will be covered as a medical benefit. |
| Insulin and Other Oral Agents | 20% coinsurance 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.) | 20% coinsurance after deductible | 40% coinsurance after Deductible | Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. |
| **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 habilitative 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 | |
| Chemotherapy - Outpatient Facility | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| Hospice | 20% coinsurance after deductible | 40% coinsurance after Deductible | 210 days per plan year |
| Home Health Care | 20% coinsurance after deductible | 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 | $10/$30/50% after deductible | Not Covered | |

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| **Prescription Drug Coverage** | | | |
| Mail Order | 2.5 copay - 90 day supply after deductible | Not Covered | |
| Medicare Part D Creditable Coverage Status | Yes | N/A | |
| **Pediatric Vision Services** | | | |
| Routine Exam | 20% coinsurance after deductible | Not Covered | One routine eye exam covered in full every other year |
| Medical Eye Exam | 20% coinsurance after deductible | 40% coinsurance after Deductible | |
| Standard Plastic Lenses, Frames and Conventional Contact Lenses | 10% coinsurance after deductible | Not Covered | Cover standard frames/lenses OR contact lenses every 12 months |
| **Adult Vision Services** | | | |
| Routine Exam | 20% coinsurance after deductible | Not Covered | One routine eye exam covered in full every other year |
| Medical Eye Exam | 20% coinsurance after deductible | 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.

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