1-800-544-2583 bcbswny.com

Benefit Summary:

Effective on or after 1/1/2020

	WNY Silver 7100 align Tiered (2020)			
Class: 1301	**Optimum Choice Cost Share**	**Flexible Choice Cost Share**	**Non-Participating Cost Share**	**Additional Information**
General Information				
Provider Network	200 Network			
Deductible	$1,900 single / $3,800 family	$5,000 single / $10,000 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	True Family - any individual within a family may be held responsible for the entire family amount	
Coinsurance	N/A	50% coinsurance after deductible	50% coinsurance after deductible	
Out of Pocket Maximum	$6,900 single / $13,800 family combined with Flexible Choice	$6,900 single / $13,800 family combined with Optimum Choice	$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	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			

A division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

	WNY Silver 7100 align Tiered (2020)			
Class: 1301	**Optimum Choice Cost Share**	**Flexible Choice Cost Share**	**Non-Participating Cost Share**	**Additional Information**
Prescription Drug Coverage				
Prescription Drugs	$5/$30/50% after deductible	N/A	N/A	
Mail Order	2.5 copays per 90 day supply	Not Covered	Not Covered	
Is Rx subject to Medical Deductible?	Yes			
Physician and Other Services				
Primary Office Visit	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Specialist Office Visit	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Telemedicine	Covered in full after deductible	Not covered	Not covered	
Allergy Injections	$25 copayment/$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Allergy Testing	$25 copayment/$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Emergency and Urgent Care Services				
Emergency Room	$250 copayment after deductible	Covered as Optimum Choice	Covered as Optimum Choice	Cost-share waived if admitted
Ambulance	$250 copayment after deductible	Covered as Optimum Choice	Covered as Optimum Choice	
Urgent Care Center	$75 copayment after deductible	$75 copayment after deductible	Covered as Optimum Choice	
Preventive Services				
Bone mineral density measurement or test	Covered in full not subject to deductible	Covered in full not subject to deductible	50% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	Covered in full not subject to deductible	50% coinsurance after deductible	
Immunizations	Covered in full not subject to deductible	Covered in full not subject to deductible	50% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	Covered in full not subject to deductible	50% coinsurance after deductible	
Routine Physical Exam	Covered in full not subject to deductible	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	Covered in full not subject to deductible	50% coinsurance after deductible	

	WNY Silver 7100 align Tiered (2020)			
Class: 1301	Optimum Choice Cost Share	Flexible Choice Cost Share	Non-Participating Cost Share	Additional Information
Hospital Services				
Inpatient Hospital	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$150 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Skilled Nursing Facility	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Diagnostic Testing Services				
Laboratory Tests	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Radiology	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Maternity Services				
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Maternity	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Mental Health and Substance Abuse				
Inpatient Mental Health	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Mental Health	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$750 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Substance Abuse	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services				
Diabetic Equipment	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Insulin and Other Oral Agents	$25 copayment after deductible	50% 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)	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	

	WNY Silver 7100 align Tiered (2020)			
Class: 1301	**Optimum Choice Cost Share**	**Flexible Choice Cost Share**	**Non-Participating Cost Share**	**Additional Information**
Rehabilitation Services				
Chiropractic Care	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Additional Services				
Chemotherapy - Outpatient Facility	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Durable Medical Equipment	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Home Health Care	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	210 days per year
Prosthetics and orthotics	50% coinsurance after deductible	50% 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.
Dialysis	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	
Wellness Card	$250 per contract	N/A	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	Covered in full not subject to deductible	Not covered	One routine exam every year, coverage up to Age 19
Medical Eye Exam	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	

	WNY Silver 7100 align Tiered (2020)			
Class: 1301	**Optimum Choice Cost Share**	**Flexible Choice Cost Share**	**Non-Participating Cost Share**	**Additional Information**
Adult Vision Services				
Routine Exam	Covered in full not subject to deductible	Covered in full not subject to deductible	Not covered	One exam every year
Medical Eye Exam	$50 copayment after deductible	50% coinsurance after deductible	50% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**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.