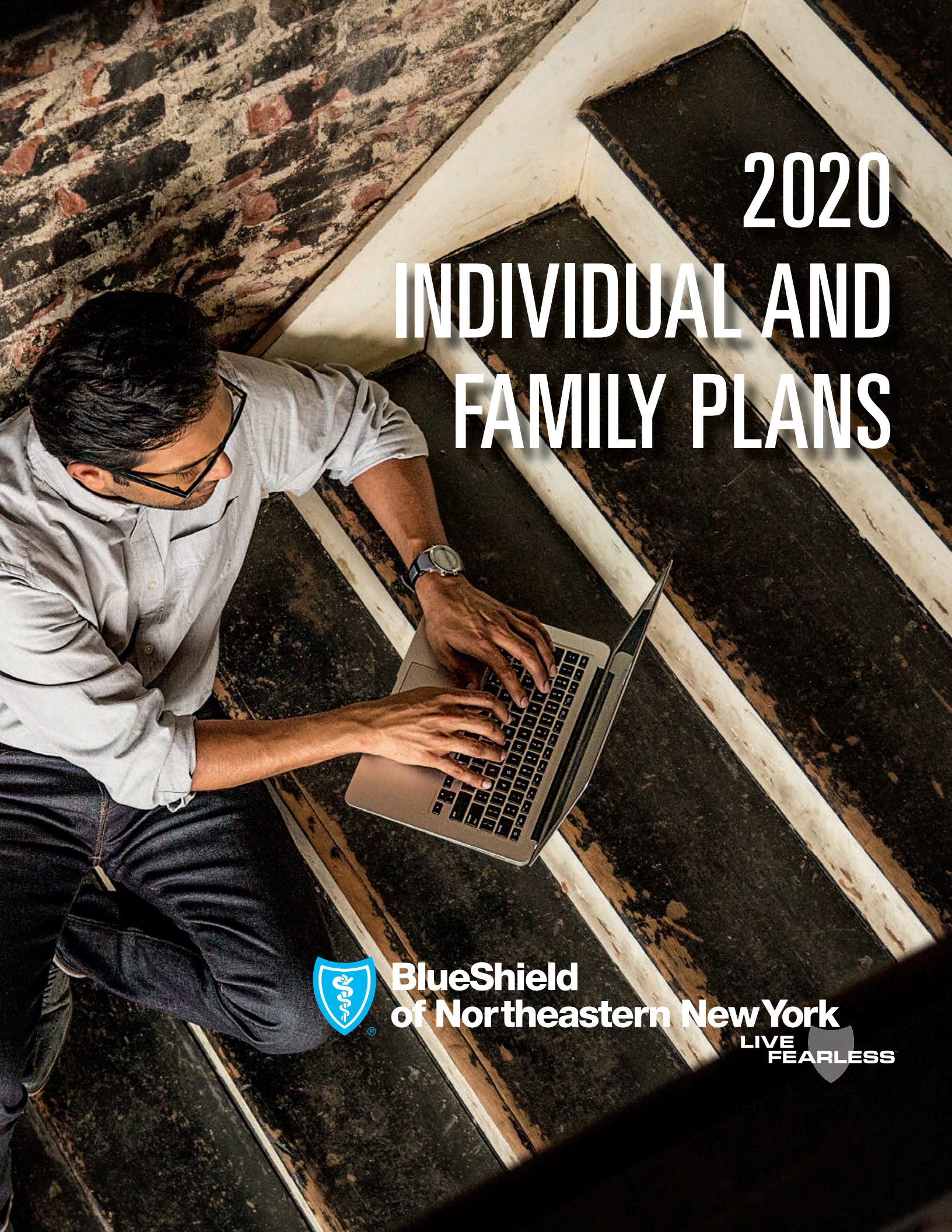


2020 INDIVIDUAL AND FAMILY PLANS

BlueShield of Northeastern New York

LIVE FEARLESS

Benefit of BlueShield

The security of a card recognized worldwide

When you choose BlueShield of Northeastern New York, you and everyone listed on your card get access to outstanding local doctors, hospitals, and specialty practices. And, if you're traveling, you can trust that BlueShield is your direct link to emergency care anywhere in the world.

It pays to be healthy

Enjoy a $250 no-strings-attached wellness debit card and earn extra cash.

- Your favorite health and wellness activities are now more affordable with the wellness debit card offered with every plan.* Visit **bsneny.com/wellnesscard** to learn more.
- Earn $25 when you complete a confidential health assessment survey. Your covered spouse can complete the assessment and earn $25, too.** Visit **bsneny.com/ha** to get started.

Low-cost pharmacy options

- Generic oral contraceptives are covered in full.
- Mail-order drugs are 2.5 copays per 90-day supply.
- Over 600 prescription drugs covered in full with the preventive drug list on Destination 65 plans only.

More than 65 free preventive services, including:

- Well child visits and immunizations
- Routine physicals
- Routine OB-GYN and mammograms
- Colorectal cancer screenings

Visit **bsneny.com/preventive** for a complete list.

Manage your health and benefits online

Get access to easy-to-use online tools and mobile apps. Go to **bsneny.com/register** to get started.

Comprehensive health and wellness programs

Online resources, local classes, support groups, and workshops.

Telemedicine hosted by Doctor On Demand®

$0 copay after deductible on HSA-qualified plans and $0 copay not subject to deductible on non-HSA-qualified plans. Connect with a doctor face to face 24/7 by phone, tablet, or computer.

Additional ways to save

Select HSA-eligible high-deductible plans include a preventive prescription drug benefit. This means that certain generic drugs and some medications for diabetes and asthma will no longer be subject to a deductible requirement, helping lower prescriptions costs.

It's easy to enroll

Call us at 1-800-700-8482 or visit **ShopShieldPlans.com** to learn more about your health insurance options, or see if you qualify for a subsidy to help pay for your health plan.

*One $250 no-strings-attached wellness debit card per contract with 2020 BlueShield of Northeastern New York individual and small group plans.

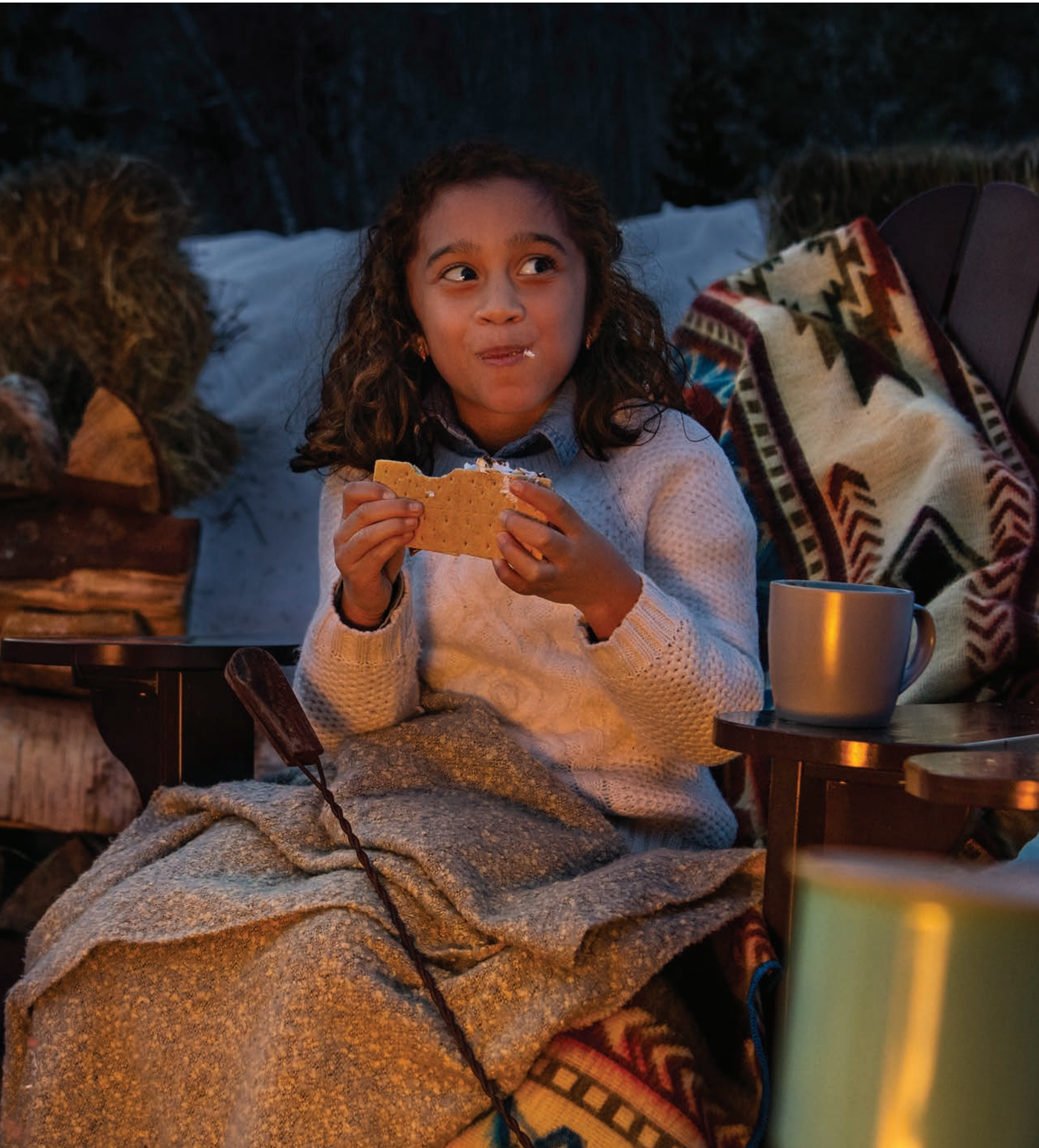
**$25 each when a subscriber and/or covered spouse completes a health survey; max $50 per contract. Available to subscribers and their covered spouses who are enrolled in individual and small group plans.

2020 Individual Plans

Levels of coverage

Plans are designed based on four metal levels that match the percentage of costs covered.

Generally, as the metal level goes down, the monthly premium goes down while the out-of-pocket cost-share goes up.



PLATINUM 90% costs covered by your premium — 10% out-of-pocket costs

GOLD 80% costs covered by your premium — 20% out-of-pocket costs

SILVER 70% costs covered by your premium — 30% out-of-pocket costs

BRONZE 60% costs covered by your premium — 40% out-of-pocket costs

		2020 PLATINUM PLANS	2020 GOLD PLANS	
		Platinum Standard	Gold Standard	Gold Destination 65
				NEW for 2020
Monthly Premium Individual/ Family	Individual	$997.06	$817.21	$748.77
	Individual and spouse/domestic partner	$1,994.11	$1,634.42	$1,497.54
	Individual and child(ren)	$1,694.99	$1,389.26	$1,272.91
	Family	$2,841.61	$2,329.05	$2,133.99
In-Network	In-network deductible (single/family)	$0	$600/$1,200 embedded	$1,400/$2,800 true family
	Out-of-pocket maximum (single/family)	$2,000/$4,000 embedded	$4,000/$8,000 embedded	$5,000/$10,000 embedded
Out-of-Network	Out-of-network deductible (single/family)	$5,000/$10,000 embedded	$5,000/$10,000 embedded	N/C
	Out-of-network out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	$10,000/$20,000 embedded	N/C
Medical Services	PCP/specialist	$15/$35	$25/$40 after deductible	$10/$30 after deductible
	Laboratory services	$35	$40 after deductible	$10 after deductible
Prescription Drugs	Tier 1/Tier 2/Tier 3	$10/$30/$60	$10/$35/$70 (not subject to deductible)	$5/$50/50% after deductible
Inpatient/ Outpatient Services	Inpatient hospital	$500	$1,000 after deductible	$290 copayment per day for 5 days per admission after deductible
	Outpatient facility fee	$100	$100 after deductible	$300 after deductible
	Emergency room/ ambulance	$100	$150 after deductible	$90 after deductible
	Urgent care	$55	$60 after deductible	$65 after deductible
Diabetic Services	Drugs/supplies	$15	$25 after deductible	$10 after deductible
Vision Benefits	Pediatric annual exam (routine)	$15	$25 after deductible	$0
	Adult vision discount program†	Standard	Standard	Enhanced
				HSA-eligible

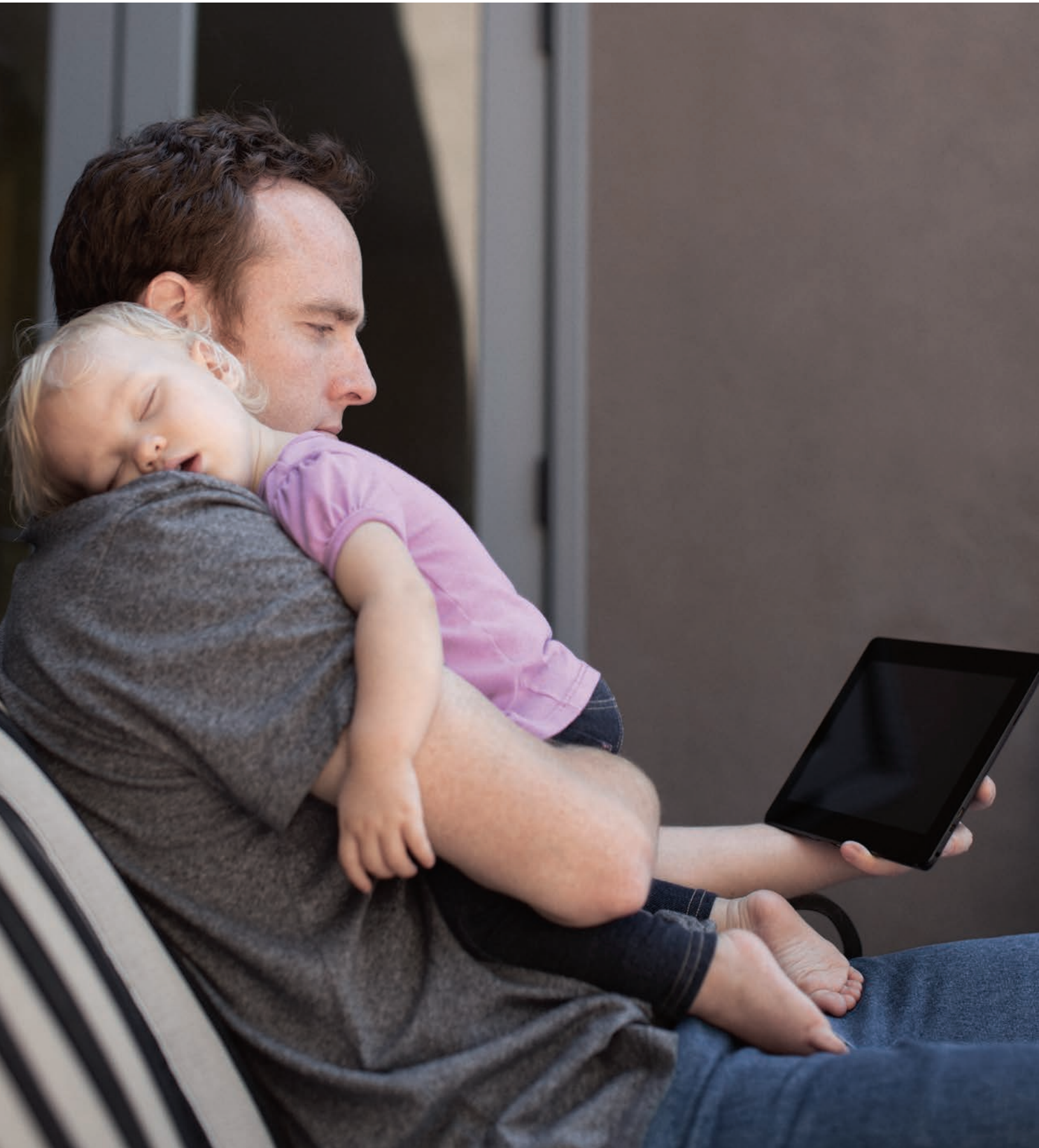
† Vision benefit administered by Davis Vision.

2020 Individual Plans

Levels of coverage

Plans are designed based on four metal levels that match the percentage of costs covered.

Generally, as the metal level goes down, the monthly premium goes down while the out-of-pocket cost-share goes up.



PLATINUM 90%	GOLD 80%	SILVER 70%	BRONZE 60%
costs covered by your premium	costs covered by your premium	costs covered by your premium	costs covered by your premium
10% out-of-pocket costs	20% out-of-pocket costs	30% out-of-pocket costs	40% out-of-pocket costs

		2020 SILVER PLANS		2020 BRONZE PLANS
		Silver Standard	Silver Destination 65	Bronze Standard
			NEW for 2020	
Monthly Premium Individual/ Family	Individual	$636.10	$582.80	$466.98
	Individual and spouse/domestic partner	$1,272.19	$1,165.61	$933.96
	Individual and child(ren)	$1,081.37	$990.77	$793.87
	Family	$1,812.88	$1,660.99	$1,330.89
In-Network	In-network deductible (single/family)	$1,300/$2,600 embedded	$2,500/$5,000 true family	$4,425/$8,850 embedded
	Out-of-pocket maximum (single/family)	$7,900/$15,800 embedded	$6,400/$12,800 embedded	$8,150/$16,300 embedded
Out-of-Network	Out-of-network deductible (single/family)	$5,000/$10,000 embedded	N/C	$5,000/$10,000 embedded
	Out-of-network out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	N/C	$10,000/$20,000 embedded
Medical Services	PCP/specialist	$30/$50 after deductible	$15/$40 after deductible	3 PCP visits covered in full; 50% after deductible for additional visits
	Laboratory services	$50 after deductible	$10 after deductible	50% after deductible
Prescription Drugs	Tier 1/Tier 2/Tier 3*	$10/$35/$70 (not subject to deductible)	$5/$50/50% after deductible	$10/$35/$70 after deductible
Inpatient/ Outpatient Services	Inpatient hospital	$1,500 after deductible	$360 copayment per day for 5 days per admission after deductible	50% after deductible
	Outpatient facility fee	$150 after deductible	$450 after deductible	50% after deductible
	Emergency room/ ambulance	$250/$150 after deductible	$90 after deductible	50% after deductible
	Urgent care	$70 after deductible	$65 after deductible	50% after deductible
Diabetic Services	Drugs/supplies	$30 after deductible	$15 after deductible	50% after deductible
Vision Benefits	Pediatric annual exam (routine)	$30 after deductible	$0	50% after deductible
	Adult vision discount program†	Standard	Enhanced	Standard
			HSA-eligible	

*Select preventive drugs are at $0 cost-share.
† Vision benefit administered by Davis Vision.

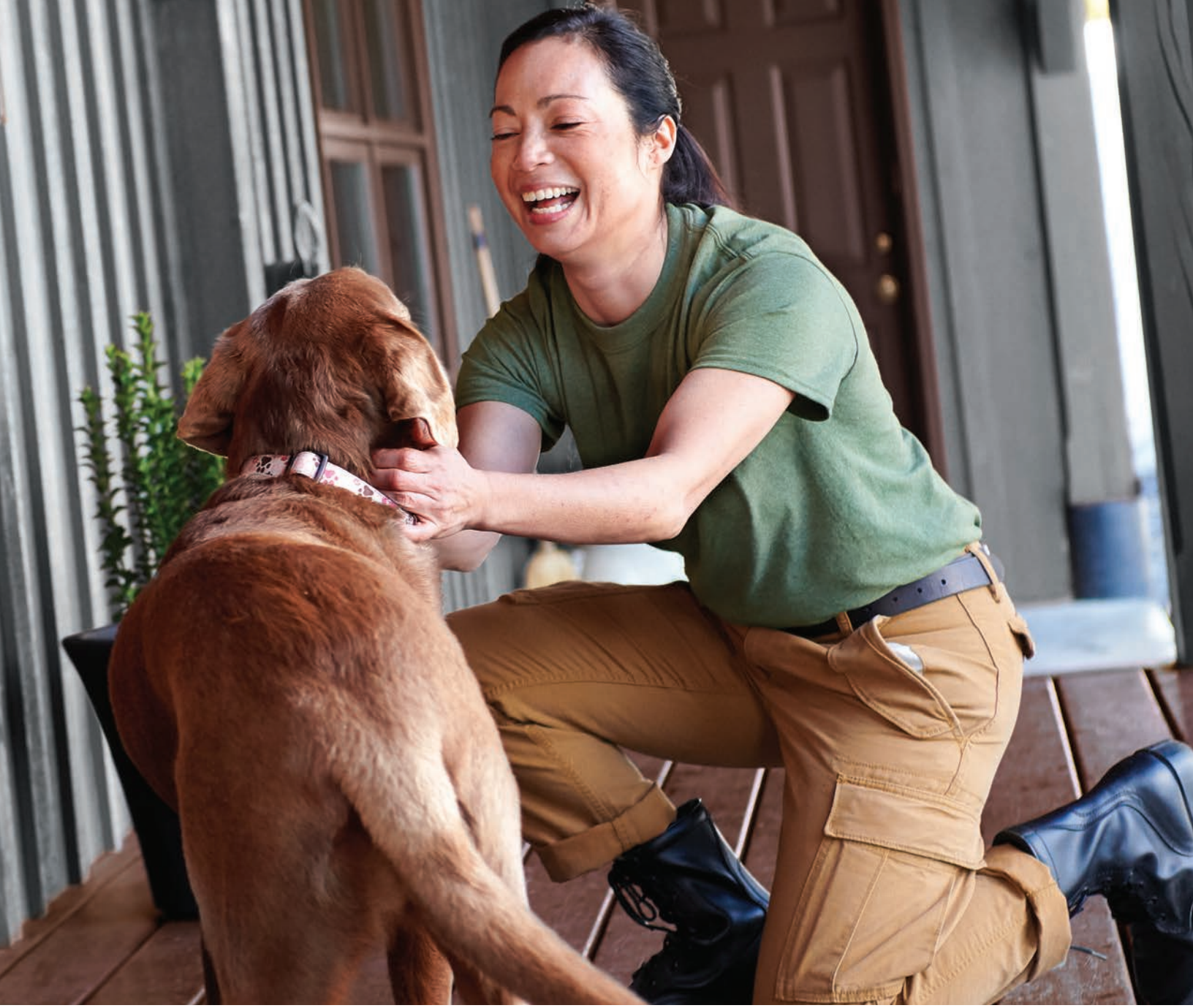
All Dental Plans

2020 Individual Offering

	Blue Pediatric Dental* (PPO)	Blue Value Dental 1* (PPO)	Blue Value Dental 2 (PPO)	Blue Value Dental 3** (PPO)
Monthly Premium				
Individual	$31.94 (per child)	$30.70	$41.13	$43.79
Individual and spouse/ domestic partner		$61.40	$82.26	$87.58
Individual and child(ren)		$79.52	$95.11	$111.32
Family		$124.35	$152.75	$174.82
Benefits	Children to age 19 years	Adult/family	Adult/family	Adult/family
Deductible (embedded)	N/A	$50 per member/$150 family maximum (per calendar year) Applies to basic restorative and major dental services	$50 per member/$150 family maximum (per calendar year) Applies to basic restorative and major dental services	$50 per member/$150 family maximum (per calendar year) Applies to basic restorative and major dental services
Annual benefit maximum	N/A	$750 per member per calendar year	$1,250 per member per calendar year	$1,500 per member per calendar year
Out-of-pocket maximum	$350 (1 child) $700 (2 or more children) (per calendar year)	N/A	N/A	N/A
Orthodontic lifetime maximum (pediatric and adult cosmetic: routine braces)	N/A	N/A	N/A	$1,000 per member per lifetime
Preventive/diagnostic care (exam, cleaning, X-rays)	$20 copayment per visit	$0 copayment per visit	$0 copayment per visit	$0 copayment per visit
Basic restorative (fillings, extractions, periodontics, endodontics)	50% coinsurance	50% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Major dental (bridges, crowns, dentures)	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Orthodontic services (medically necessary)	50% coinsurance applies to children age 19	50% coinsurance applies to children age 19	50% coinsurance applies to children age 19	50% coinsurance applies to children age 19
Orthodontic services (cosmetic: routine braces)	N/A	N/A	N/A	50% coinsurance applies to children and adults

Blue Pediatric Dental benefits and cost-sharing are included in all Blue Value Dental plans.

For plan information, please call 1-800-700-8482.



Dental and vision benefits

Dental options

Our dental plans cover pediatric essential health benefits (as outlined in the Affordable Care Act) and adult dental benefits. Options include comprehensive oral health coverage, coverage for routine braces, and out-of-network coverage. Go to **bsneny.com/dentaloptions** to view our dental plans.

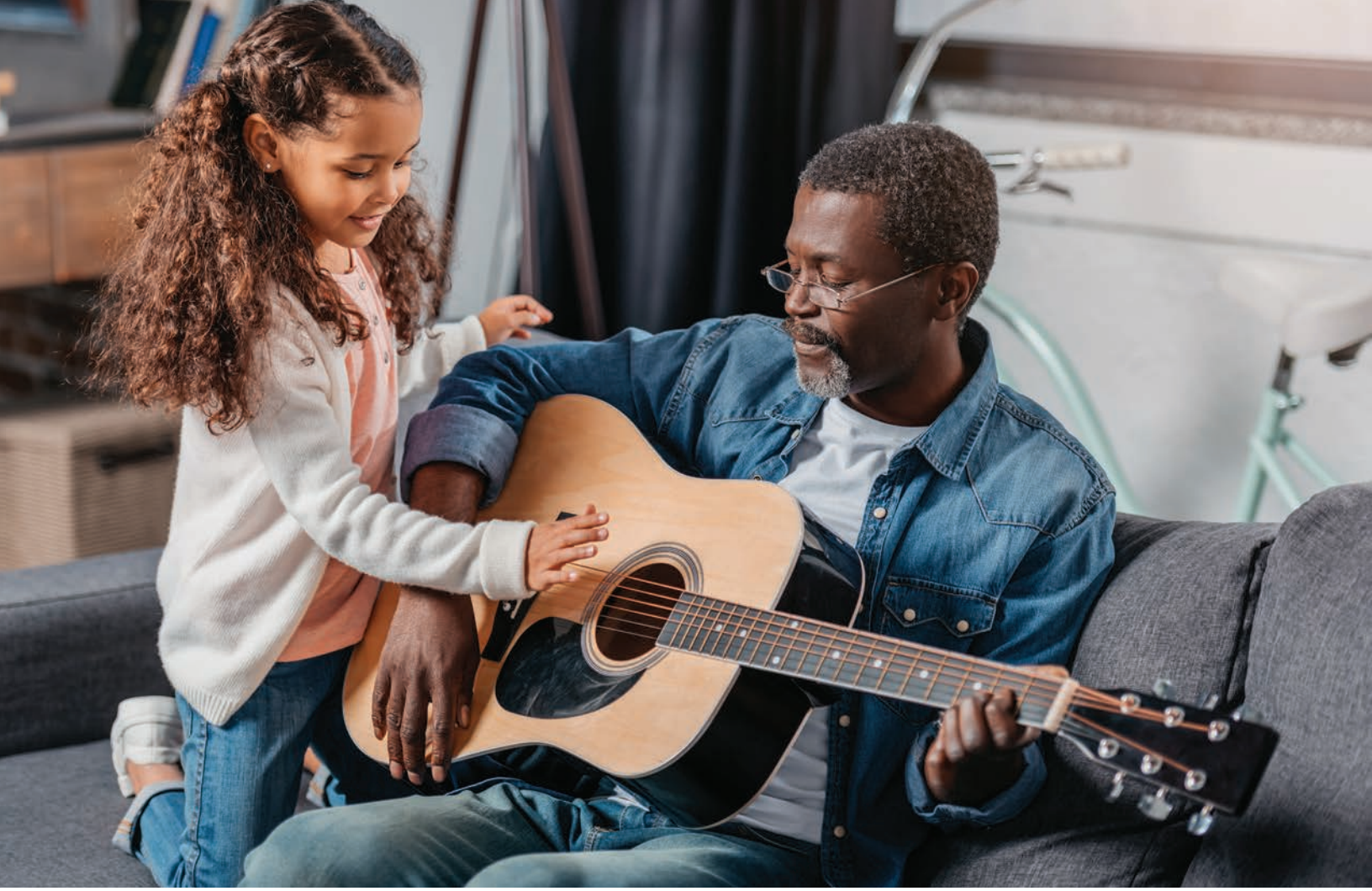
Vision options

From pediatric essential health benefits including routine eye exams, frames, and lenses to exams and eyewear discounts for adults, we offer a network of vision providers and benefits to make sure you see and look your best. Visit **bsneny.com/visionbenefits** for more information on our vision discount program and offerings, administered by Davis Vision.

Participating providers may not balance bill the member. Members have the option to receive dental services from a provider who does not participate in the BlueShield of Northeastern New York contracted network of providers. Out-of-network services are reimbursed at 100% of the in-network fee schedule and the nonparticipating provider may balance bill the member. Visit **bsneny.com** to check if the dentist is participating in the network or located within our operating area.

*Available on New York State of Health Marketplace.

**Blue Value Dental 3 includes coverage for children up to age 19 for medically necessary orthodontics subject to an out-of-pocket maximum and cosmetic orthodontics (routine braces) subject to a lifetime maximum per member. Adults and adult dependents (19 and above) have coverage for cosmetic orthodontics (routine braces) subject to a lifetime maximum per member.



Annual Benefit Limits

Habilitation (PT/OT/ST)

60 combined visits per condition per plan year

Rehabilitation, outpatient (PT/OT/ST)

60 combined visits per condition per plan year

Rehabilitation, inpatient (PT/OT/ST)

60 combined visits per plan year

Home health care

40 visits per plan year

Hearing aids

- Single purchase every three years
- Members are entitled to discounts through TruHearing®

Hospice

210 days per plan year, five visits per plan year for family bereavement

Substance abuse, outpatient

Unlimited, 20 visits per plan year for family counseling

Skilled nursing facility

Unlimited, 200 days per year for Standard plans

THE NAME TRUSTED
FOR OVER 70 YEARS.

Call us
1-800-700-8482

Visit us online
ShopShieldPlans.com

BlueShield of Northeastern New York
LIVE FEARLESS

The information in this document is not intended as a contract. Rates vary based on the overall benefit package and are subject to change without notice.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia linguistica. Llame al 1-833-735-4515 (TTY 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-735-4515 (TTY 711).

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