BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary:

Effective on or after 1/1/2020

	NENY Bronze Value (2020)		
Class ID: 4301	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Provider Network	200 Plus Network		
Deductible	$6,900 single / $13,800 family	Not covered	
Deductible Administration Type	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	Not Covered	
Coinsurance	Covered in full after deductible	Not covered	
Out of Pocket Maximum	$6,900 single / $13,800 family	Not covered	
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	Not Covered	
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		
Prescription Drug Coverage			
Prescription Drugs	0%/0%/0% after deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx Subject To Deductible?	Yes		

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Physician and Other Services			
Primary Office Visit	Covered in full after deductible	Not covered	
Specialist Office Visit	Covered in full after deductible	Not covered	
Telemedicine	Covered in full after deductible	Not covered	
Allergy Injections	Covered in full after deductible	Not covered	
Allergy Testing	Covered in full after deductible	Not covered	
Outpatient Surgical Procedures (in physician's office)	Covered in full after deductible	Not covered	
Emergency and Urgent Care Services			
Emergency Room	Covered in full after deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	Covered in full after deductible	Covered as in-network	
Urgent Care Center	Covered in full after deductible	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full not subject to deductible	Not covered	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	Not covered	
Immunizations	Covered in full not subject to deductible	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	Not covered	
Routine Physical Exam	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	Not covered	
Hospital Services			
Inpatient Hospital	Covered in full after deductible	Not covered	
Outpatient Surgical Procedure (Facility)	Covered in full after deductible	Not covered	
Skilled Nursing Facility	Covered in full after deductible	Not covered	
Diagnostic Testing Services			
Laboratory Tests	Covered in full after deductible	Not covered	
Radiology	Covered in full after deductible	Not covered	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	Covered in full after deductible	Not covered	
Inpatient Maternity	Covered in full after deductible	Not covered	
Mental Health and Substance Abuse			
Inpatient Mental Health	Covered in full after deductible	Not covered	
Outpatient Mental Health	Covered in full after deductible	Not covered	

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Mental Health and Substance Abuse			
Inpatient Substance Abuse - Rehab	Covered in full after deductible	Not covered	
Inpatient Substance Abuse - Detox	Covered in full after deductible	Not covered	
Outpatient Substance Abuse	Covered in full after deductible	Not covered	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services			
Diabetic Equipment	Covered in full after deductible	Not covered	
Insulin and Other Oral Agents	Covered in full after deductible	Not covered	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)	Covered in full after deductible	Not covered	
Rehabilitation Services			
Chiropractic Care	Covered in full after deductible	Not covered	
Physical - Occupational - Speech Therapies	Covered in full after deductible	Not covered	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	Covered in full after deductible	Not covered	
Additional Services			
Durable Medical Equipment	Covered in full after deductible	Not covered	
Prosthetics and Appliances	Covered in full after deductible	Not covered	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	Covered in full after deductible	Not covered	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	Covered in full after deductible	Not covered	210 days per year
Chemotherapy - Outpatient Facility	Covered in full after deductible	Not covered	
Dialysis	Covered in full after deductible	Not covered	
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

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Pediatric Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	One routine exam every year, coverage up to Age 19
Medical Eye Exam	Covered in full after deductible	Not covered	
Adult Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	One exam every year
Medical Eye Exam	Covered in full after deductible	Not covered	

*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.