BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary:

Effective on or after 1/1/2020

	NENY Gold Radius (2020)		
Class ID: 3402	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Provider Network	200 Plus Network		
Deductible	$750 single / $1,500 family	$5,000 single / $10,000 family	
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	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	
Coinsurance	30% coinsurance after deductible	50% coinsurance after deductible	
Out of Pocket Maximum	$8,150 single / $16,300 family	$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	
Benefit Administration Date	Plan year		
Dependent Coverage			
Dependent Age	30/30		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$10/$35/$70 not subject to deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx Subject To Deductible?	No		

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Physician and Other Services			
Primary Office Visit	$25 copayment not subject to deductible	50% coinsurance after deductible	$0 PCP cost-share for <19
Specialist Office Visit	$50 copayment not subject to deductible	50% coinsurance after deductible	
Telemedicine	Covered in full not subject to deductible	Not covered	
Allergy Injections	$25 copayment/$50 copayment not subject to deductible	50% coinsurance after deductible	
Allergy Testing	$25 copayment/$50 copayment not subject to deductible	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$50 copayment not subject to deductible	50% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$350 copayment not subject to deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	$350 copayment not subject to deductible	Covered as in-network	
Urgent Care Center	$100 copayment not subject to deductible	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full not subject to deductible	50% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	50% coinsurance after deductible	
Immunizations	Covered in full not subject to deductible	50% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	50% coinsurance after deductible	
Routine Physical Exam	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	50% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	30% coinsurance after deductible	50% coinsurance after deductible	
Skilled Nursing Facility	30% coinsurance after deductible	50% coinsurance after deductible	

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Diagnostic Testing Services			
Laboratory Tests	$25 copayment not subject to deductible	50% coinsurance after deductible	
Radiology	30% coinsurance after deductible	50% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment not subject to deductible	50% coinsurance after deductible	
Inpatient Maternity	30% coinsurance after deductible	50% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Mental Health	$25 copayment not subject to deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	30% coinsurance after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Detox	30% coinsurance after deductible	50% coinsurance after deductible	
Outpatient Substance Abuse	$25 copayment not subject to 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 not subject to deductible	50% coinsurance after deductible	
Insulin and Other Oral Agents	$25 copayment not subject to 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 not subject to deductible	50% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$25 copayment not subject to deductible	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment not subject to deductible	50% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	$50 copayment not subject to deductible	50% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	30% coinsurance after deductible	50% coinsurance after deductible	

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Additional Services			
Prosthetics and Appliances	30% 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.
Home Health Care	$50 copayment not subject to deductible	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	30% coinsurance after deductible	50% coinsurance after deductible	210 days per year
Chemotherapy - Outpatient Facility	30% coinsurance after deductible	50% coinsurance after deductible	
Dialysis	30% coinsurance after deductible	50% coinsurance after deductible	
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
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	$50 copayment not subject to deductible	50% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	One exam every year
Medical Eye Exam	$50 copayment not subject to 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.