BlueCross BlueShield of Western New York

1-800-544-2583 bcbswny.com

Benefit Summary:

Effective on or after 1/1/2020

	Gold Healthy NY (2020)		
Class ID: E401	**In-Network**	**Out-of-Network**	**Additional Information**
Provider Network	200 Network		
Deductible	$600 single / $1,200 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	N/A	Not covered	
Out of Pocket Maximum	$4,000 single / $8,000 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	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 Medical Deductible?	No		

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Physician and Other Services			
Primary Office Visit	$25 copayment after deductible	Not covered	
Specialist Office Visit	$40 copayment after deductible	Not covered	
Telemedicine	Covered in full after deductible	Not covered	
Allergy Testing	$25 copayment/$40 copayment after deductible	Not covered	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$40 copayment after deductible	Not covered	
Emergency and Urgent Care Services			
Emergency Room	$150 copayment after deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	$150 copayment after deductible	Covered as in-network	
Urgent Care Center	$60 copayment 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	$1,000 copayment after deductible	Not covered	
Outpatient Surgical Procedure (Facility)	$100 copayment after deductible	Not covered	
Skilled Nursing Facility	$1,000 copayment after deductible	Not covered	200 days per year
Diagnostic Testing Services			
Laboratory Tests	$40 copayment after deductible	Not covered	
Radiology	$40 copayment after deductible	Not covered	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment after deductible	Not covered	
Inpatient Maternity	$1,000 copayment after deductible	Not covered	

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Mental Health and Substance Abuse			
Inpatient Mental Health	$1,000 copayment after deductible	Not covered	
Outpatient Mental Health	$25 copayment after deductible	Not covered	
Inpatient Substance Abuse - Rehab	$1,000 copayment after deductible	Not covered	
Inpatient Substance Abuse - Detox	$1,000 copayment after deductible	Not covered	
Outpatient Substance Abuse	$25 copayment after deductible	Not covered	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services			
Diabetic Equipment	$25 copayment after deductible	Not covered	
Insulin and Other Oral Agents	$25 copayment 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)	$25 copayment after deductible	Not covered	
Rehabilitation Services			
Chiropractic Care	$40 copayment after deductible	Not covered	
Physical - Occupational - Speech Therapies	$30 copayment after deductible	Not covered	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	$25 copayment after deductible	Not covered	
Additional Services			
Durable Medical Equipment	20% coinsurance after deductible	Not covered	
Prosthetics and Appliances	20% coinsurance after deductible	Not covered	Shoe orthotics not covered. One prosthetic device, per limb, per lifetime (standard equipment only); For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Home Health Care	$25 copayment after deductible	Not covered	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	$25 copayment after deductible	Not covered	210 days per year
Chemotherapy - Outpatient Facility	$25 copayment after deductible	Not covered	
Dialysis	$25 copayment after deductible	Not covered	

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Additional Services			
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	$25 copayment after deductible	Not covered	One routine exam every year, coverage up to Age 19
Medical Eye Exam	$25 copayment after deductible	Not covered	
Adult Vision Services			
Routine Exam	Not covered	Not covered	
Medical Eye Exam	$25 copayment 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.