Benefits	Group #00418019 Class 00A6 Plan A – BCBS Traditional	Group #00418019 Class 00B7 Plan B – Point of Service	Group #00418019 Class 00C3 Plan C – Point of Service	Group #00418019 Class 00D4 Plan D – Point of Service
Annual Physical	$50 Copay	$15 co-pay	$15 co-pay. No co-pay for dependents under age 19.	$15 co-pay
Doctor's Office Visits & Medical Check-ups	Covered by Major Medical 20% after deductible	$15 co-pay	$15 co-pay. No co-pay for dependents under age 19.	$15 co-pay
Specialist Co-pay	Covered by Major Medical 20% after deductible	$15 copay	$15 co-pay. No co-pay for dependents under age 19.	$15 copay
Prescriptions	$10/$25/$25			
Outpatient X-Rays	$0 Copay	Covered in full.	$5 co-pay. No co-pay for dependents under age 19.	Covered in full.
Outpatient Laboratory & Pathology	Covered. Participating doctors accept payment as payment in full. $0 copay			
Emergency Services	$0 copay for Emergency Room and Urgent Care Center	$35 co-pay for emergency room. Co-pay waived if admitted. $15 copay for Urgent Care Center	$25 co-pay for emergency room. Co-pay waived if admitted. $15 copay for Urgent Care Center	$35 co-pay for emergency room. Co-pay waived if admitted. $15 copay for Urgent Care Center
Ambulance	$0 Copay			
Hospital Room & Board, Services & Supplies	Covered in full for unlimited number of days when medically necessary.			
Doctor's Hospital Visits	Covered in full for one visit per day.			

Benefits	Group #00418019 Class 00A6 Plan A – BCBS Traditional	Group #00418019 Class 00B7 Plan B – Point of Service	Group #00418019 Class 00C3 Plan C – Point of Service	Group #00418019 Class 00D4 Plan D – Point of Service
In-Hospital Consultations	Covered in full for 2 consultations per admit.			
Surgeon/Anesthesiologist Fees (Inpatient/Outpatient)	Covered. Participating doctors accept payment as payment in full.			
Out-of-Area Elective Admissions	Covered the same as in-area (all BCBSWNY hospitals accept payment as payment in full).	Covered in full if prior authorization has been obtained. If no prior authorization, payable under out-of-network benefits.		
Doctor Fees for Maternity Care	$0 copay	Covered in full after initial visit co-pay.		
Dependent Children	Covered to Age 26.			
Well Child Care	Covered in full to age 19.			
Mental Health Services Inpatient	Unlimited days – subject to medical necessity.			
Mental Health Services Outpatient	Unlimited days – subject to medical necessity.			
Alcohol & Substance Abuse Inpatient	Unlimited days – subject to medical necessity. Detox & Rehab are covered.			
Alcohol & Substance Abuse Outpatient	Unlimited days – subject to medical necessity. Detox & Rehab are covered in full.			
Chiropractic Services	$0 copay	$15 co-pay	$15 co-pay. No co-pay for dependents under age 19	$15 co-pay
Podiatrists	20% coinsurance after deductible. Routine foot care not covered.	$15 co-pay. Routine foot care is not covered.	$15 co-pay. Routine foot care is not covered. No co-pay for dependents under age 19.	$15 co-pay. Routine foot care is not covered.

Benefits	Group #00418019 Class 00A6 Plan A – BCBS Traditional	Group #00418019 Class 00B7 Plan B – Point of Service	Group #00418019 Class 00C3 Plan C – Point of Service	Group #00418019 Class 00D4 Plan D – Point of Service
Durable Medical Equipment	Covered by Major Medical. 20% after deductible.	50% coinsurance, up to $1,000 per member per calendar year.	Not covered except for diabetic equipment & supplies.	20% coinsurance.
Prosthetic Devices (Artificial Limbs, etc.)	Covered by Major Medical. 20% after deductible	Internal is covered in full. External covered at 50% coinsurance.	Internal covered in full. External not covered except for post-mastectomy prosthetics.	Internal covered in full. External not covered except for post-mastectomy prosthetics.
Outpatient Rehabilitative Therapy	Covered by Major Medical on doctor's orders for short-term restorative physical therapy. Participating providers accept the allowance as payment in full. 20% after deductible	$15 co-pay per visit for short-term restorative physical therapy for up to two consecutive months per diagnosis.	$15 co-pay for up to 30 visits per year. No co-pay for dependents under age 19.	$15 co-pay for short-term restorative physical therapy. Limit 20 visits per calendar year.
Eye Care	Medical – covered by Major Medical. Routine vision examinations are not covered. 20% after deductible. Routine not covered	Medical - $15 co-pay per office visit. One routine eye exam every calendar year, subject to $15 co-pay. Discounts on eyewear at Eye-Med vision providers.	$15 co-pay. Discounts on eyewear at Eye-Med Vision providers. No co-pay for dependents under age 19.	Medical - $15 co-pay per office visit. Routine vision exam once every two years - $15 co-pay. Annual vision exam for children age 14 & under who have documented refractive error. Discounts on eyewear at Eye-Med Vision providers.

	Group #00418019 Class 00A6	Group #00418019 Class 00B7	Group #00418019 Class 00C3	Group #00418019 Class 00D4
Benefits	**Plan A – BCBS Traditional**	**Plan B – Point of Service**	**Plan C – Point of Service**	**Plan D – Point of Service**
Diabetic Supplies	20% after deductible. Diabetic drugs covered per pharmacy benefit.	$8 copay	$5 copay No copay for dependents under age 19.	$5 copay
Skilled Nursing Facility	Unlimited days 20% coinsurance after deductible	Covered in full for up to 45 days when admission is authorized by BCBSWNY. Custodial care is not covered.	Covered in full for up to 45 days when admission is authorized by BCBSWNY. Custodial care is not covered.	Covered in full for up to 50 days when admission is authorized by BCBSWNY. Custodial care is not covered.
Home Health Care	$0 copay. 365 visit per year limit	$15 copayment per visit when approved by BCBSWNY.	$15 copayment per visit when approved by BCBSWNY. No copayment for dependents under age 19.	$15 copayment per visit when approved by BCBSWNY.
Cosmetic Surgery	Not Covered			
Out of Network	Not applicable.	$250 single, $500 family deductible. 20% coinsurance after the deductible. Out of pocket maximum is $2000 single and $4000 family.	$200 single, $400 family deductible. 20% coinsurance after the deductible. Out of pocket maximum is $3000 single and $6000 family.	$250 single, $500 family deductible. 20% coinsurance after the deductible. Out of pocket maximum is $2000 single and $4000 family.
Major Medical	$150 single, $300 family deductible. 20% coinsurance after the deductible. Out of pocket maximum is $500 single and $1000 family.	Not Applicable		

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 apply.

******Retain for your records******