Health Insurance Plan Comparison
Active EXEMPT Members

CATEGORY	Group# 00418019 Class 00A4	Group# 00418019 Class 00B4	Group# 00418019 Class 00C2	Group# 00418019 Class 00D3
	Plan A - Traditional	**Plan B - POS**	**Plan C - POS**	**Plan D - POS**
Annual Physical	$50 Allowance. Provider can bill member for the remaining amount.	$8 copayment per office visit.	$5 copayment per office visit. No copay for dependents under the age of 19.	PCP copayment per office visit.
Doctor's Office Visits & Medical Check-ups	Covered by Major Medical.*	$8 copayment per office visit.	$5 copayment per office visit. No copay for dependents under the age of 19.	$5 PCP/$10 Spec. Plus Options: $0/$15 or $5/$10
Specialist Co-pay	Covered by Major Medical.*	$8 copayment per office visit.	$5 copayment per office visit. No copay for dependents under the age of 19.	$5 PCP/$10 Spec. Plus Options: $0/$15 or $5/$10
Prescriptions	Three-tier prescription coverage: $7/$15/$25 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.	Three-tier prescription coverage: $7/$15/$30 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.	Three-tier prescription coverage: $7/$15/$35 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.	Three-tier prescription coverage: $7/$15/$35 copayment per prescription for up to a 30 day supply when written by a participating physician and filled at a participating pharmacy. Oral contraceptives are covered.
Outpatient X-Rays	Covered. Participating doctors accept payment as payment in full.	Covered in full.	$5 copayment. No copayment for dependents under age 19.	Covered in full.
Outpatient Laboratory & Pathology	Covered in full.			
Emergency Services	Hospital charges covered in full. Surgical procedures and related services covered.	$35 copayment for emergency room. Copayment is waived if admitted.	$25 copayment for worldwide emergency room use. Copayment is waived if patient is admitted.	$35 copayment for worldwide emergency room (ER) use including physicians' fees for life threatening emergencies. Copayment for emergency room waived if admitted.
Urgent Care	Covered in Full	$8 copay	$5 copay	PCP copayment
Ambulance	Covered in full when medically necessary.			
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.			
In-Hospital Consultations	Covered in full for 2 consultations per admit.			
Surgeon/Anesthesiologist Fees (Inpatient/Outpatient)	Covered 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 OON benefits.		
Doctor Fees for Maternity Care	Covered. Participating doctors accept payment as payment in full.	Covered in full after initial visit copay.		
Dependent Children	Covered to Age 26.			

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	Plan A - Traditional	**Plan B - POS**	**Plan C - POS**	**Plan D - POS**
Well Child Care	Covered in full to age 19.			
Mental Health Services Inpatient	Unlimited Days; Subject to medical necessity; Covered in full.			
Mental Health Services Outpatient	Unlimited Days; subject to medical necessity; Covered in full.			
Alcohol & Substance Abuse Inpatient	Unlimited Days; subject to medical necessity Detox & Rehab are covered; Covered in full.			
Alcohol & Substance Abuse Outpatient	Unlimited Days; subject to medical necessity Detox & Rehab are covered; Covered in full.			
Chiropractic Services	Covered in full when medically necessary. Participating providers accept payment as payment in full.	$8 copayment when medically necessary.	$5 copayment when medically necessary. No copay for dependents under age 19.	$5 co-payment for unlimited number of visits when medically necessary. No referral necessary.
Podiatrists	Covered for non-routine care. Participating providers accept allowance as payment in full.	Covered with an $8 member copayment for medically necessary services. Routine foot care is not covered.	Covered with an $5 member copayment for medically necessary services. Routine foot care is not covered. No copayment for dependents under age 19.	Specialist copayment when medically necessary. Routine foot care is not covered.
Durable Medical Equipment	Covered by Major Medical.*	50% coinsurance, up to $1000 per member per calendar year.	Not covered except for diabetic equipment and supplies.	Durable medical equipment is covered at 20% copayment when arranged for by a BCBSWNY physician and received through a participating provider.
Prosthetic Devices (Artificial Limbs, etc.)	Covered by Major Medical.*	Internal is covered in full. External covered at 50%.	Internal prostheses covered in full. External not covered except for post-mastectomy prosthetics.	Internal prostheses 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.	$15 copayment per visit for short-term restorative physical therapy for up to two consecutive months per diagnosis.	Covered with a $5 copayment for up to 30 visits per year. No copayment for dependents under age 19.	Specialist co-payment per visit for short-term restorative physical therapy; up to 20 visits covered in a calendar year when authorized by BCBSWNY.
Eye Care	Medical - covered by Major Medical.* Routine vision examinations are not covered.	Medical - $8 copayment per office visit. One routine eye exam will be covered once every calendar year, subject to a copayment of $10. Discounts on eyewear at Davis Vision providers.	Covered for a $5 copayment. Discounts on eyewear at Davis Vision providers. No copay for dependents under age 19.	Medical - $10 copayment per office visit. Routine vision exam once every two years with a $10 copayment for adults. Annual vision exam for children age 14 and under who have documented refractive error. Up to 60% savings on eyewear at Davis Vision providers.

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Diabetic Supplies	Insulin, oral agents, equipment, and supplies covered after deductible and 20% copayment. For Major Medical type riders with a separate prescription drug card, member may either pay prescription drug copayment or Major Medical copayment after deductible, whichever is less.	Diabetic durable medical equipment - $8 copayment. Diabetic supplies up to a 30 day supply - $8 copayment. Insulin up to a 30 day supply - $8 copayment or RX copayment, whichever is less.	Diabetic durable medical equipment - $5 copayment. Diabetic supplies up to a 30 day supply - $5 copayment. Insulin up to a 30 day supply - $5 copayment or RX copayment, whichever is less. No copay for dependents under age 19.	Diabetic equipment and supplies subject to $5 copayment. Insulin and oral agents are covered, subject to prescription drug or office visit copayment, whichever is less. Certain items are subject to prior approval.
Skilled Nursing Facility	Unlimited days for skilled level of care by major medical when admitted to a participating facility within 30 days of discharge from a hospital if continued skilled care is medically necessary. 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 45 days when admission is authorized by BCBSWNY. Custodial care is not covered.	Covered in full for up to 50 days per member per year when admission is authorized by BCBSWNY.
Home Health Care	Covered in full for up to 365 visits per calendar year from approved agencies in lieu of hospital or Skilled Nursing Facility stay, when ordered by a physician.	$8 copayment per visit when approved by BCBSWNY.	$5 copayment per visit when approved by BCBSWNY. No copay for dependents under age 19.	Specialist co-payment per visit.
Cosmetic Surgery	Elective cosmetic surgery is not covered. Coverage for services in connection with reconstructive surgery per BCBSWNY medical guidelines will be provided.			
Out of Network	Not Applicable	20% coinsurance, $250/$500 deductible with an out of pocket max of $2,000/$4,000	20% coinsurance, $200/$400 deductible with an out of pocket max of $3,000/$6,000	20% coinsurance, $250/$500 deductible with an out of pocket max of $2,000/$4,000
Major Medical	*Except where otherwise stated, BCBSWNY has a calendar year deductible of $150 per individual ($300 per family). Where the deductible applies, and when it has been met, Major Medical pays 80% of the Schedule of Allowances. The out-of-pocket limit of $500 per individual ($1,000 per family) is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. Unlimited Lifetime Maximum.	Not applicable.		

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