Plan Comparison
Active LOCAL 264 and PCTEA Members

CATEGORY	Group# 00418019 Class 00A5	Group# 00418019 Class 00B6
	PLAN A TRADITIONAL BLUE CROSS	**PLAN B Base Plan Community Blue POS 204 Plus**
Annual Physical	$50 Allowance. Provider can bill member for the remaining amount.	$10 or $15 Primary Care Physician (PCP)
Doctor's Office Visits & Medical Check-ups	Covered by Major Medical.* (*See Major Medical below.) Participating doctors accept our allowance as payment in full.	Employee Chooses Co-Pay Structure $10 PCP/ $20 Specialist OR $15 PCP/ $15 Specialist
Specialist Co-pay	Covered by Major Medical.* (*See Major Medical below.) Participating doctors accept our allowance as payment in full.	Employee Chooses Co-Pay Structure $20 or $15 co-pay
Prescriptions	Three-tier prescription coverage: $1/$15/$30 co-payment 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. (Voluntary Mail Order 3 copays per 90 day supply.)	Three-tier prescription coverage: $1/$15/$30 co-payment 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. (Voluntary Mail Order) Mail Order: one co-payment for 90 day supply available.
Outpatient X-Rays	$0 co-pay at participating facilities.	Covered in full.
Outpatient Laboratory & Pathology	$0 co-pay at participating facilities.	Covered in full.
Emergency Services	$0 co-pay for Emergency Room and Urgent Care Center.	$50 co-payment for emergency room. Co-payment is waived if admitted. PCP co-pay for Urgent Care Center.
Ambulance	Covered in full when medically necessary.	$50 co-pay.
Hospital Room & Board, Services & Supplies	Covered in full when medically necessary.	$250 Single/$500 Family annual maximum.
Doctor's Hospital Visits	Covered in full for one visit per day.	

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.

Revised October 2021

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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.	Covered in full.
Out-of-Area Elective Admissions	Covered the same as in-area (all BCBSWNY hospitals accept payment as payment in full).	$250 co-pay for 365 days when medically necessary. $250 Single/$500 Family annual maximum for all inpatient services including: Hospital, Rehab, Detox, Skilled Nursing and Mental Health when prior authorization has been obtained. Without prior authorization, OON benefits apply.
Doctor Fees for Maternity Care	$0 co-pay	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	Hospital stays covered up to 30 days per calendar year. Further days covered in full by Major Medical. NY State operated psychiatric hospital (365 days per year). Physicians' fees covered for all covered inpatient days.	$250 co-pay for 365 days when medically necessary. $250 Single/$500 Family annual maximum for all inpatient services including: Hospital, Rehab, Detox, Skilled Nursing and Mental Health.
Mental Health Services Outpatient	Covered in full for 40 visits per member per calendar year.	Zero co-payment; *no visit limit as long as medically necessary.*
Alcohol & Substance Abuse Inpatient	Detoxification is covered in full. Rehabilitation is not covered.	In patient Detox - $250 Single/$500 Family co-pay. In patient Rehab $250 Single/$500 Family for up to 30 days.

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Alcohol & Substance Abuse Outpatient	Covered for up to 60 outpatient visits per calendar year. Participating doctors accept payment as payment in full.	$15 or $20 specialist co-payment for up to 60 outpatient visits per member per calendar year. $15/$20 is the subscriber's choice, and a co-pay is required for each outpatient service because each visit is billed separately.
Chiropractic Services	Covered in full when medically necessary. Participating providers accept payment as payment in full.	$15 co-payment when medically necessary.
Podiatrists	Covered for non-routine care. Participating providers accept allowance as payment in full.	Specialist co-pay for medically necessary services. Routine foot care is not covered.
Durable Medical Equipment	Covered by Major Medical.* (*See Major Medical below)	20% coinsurance. No annual maximum.
Prosthetic Devices (Artificial Limbs, etc.)	Covered by Major Medical.* (*See Major Medical below)	Internal is covered in full. External covered at 80%.
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.	Specialist co-pay for Physical, Occupational or Speech therapy. 60 visits per plan year.
Eye Care	Medical - covered by Major Medical.* (*See Major Medical below.) Routine vision examinations are not covered.	Medical - Specialist co-pay per office visit. One routine eye exam will be covered once every calendar year, subject to a co-payment of $10. Discounts on eyewear at Davis Vision Providers.
Diabetic Supplies	Insulin, oral agents, equipment, and supplies covered after deductible and 20% co-payment. For Major Medical type riders with a separate prescription drug card, member may either pay prescription drug co-payment or Major Medical co-payment after deductible, whichever is less.	Diabetic equipment & supplies - PCP co-payment. Insulin - up to a 30 day supply - PCP co-payment or Rx co-payment, whichever is less.

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Skilled Nursing Facility	365 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.	$250 for 365 days when admission is authorized by BCBSWNY. Custodial care is not covered. $250 Single/$500 Family annual maximum for all inpatient services including: Hospital, Rehab, Detox, Skilled Nursing and Mental Health.
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.	Specialist co-payment per visit when approved by BCBSWNY.
Cosmetic Surgery	Elective Cosmetic surgery is not covered. We will, however, provide coverage for services in connection with reconstructive surgery per BCBSWNY medical guidelines.	
Out of Network	Not Applicable	20% coinsurance, $250 Single/$500 Family 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.