BlueCross BlueShield of Western New York

1-800-544-2583 bcbswny.com

Benefit Summary for Group:

Daemen College

Effective Date: 6/1/2019

	POS 206		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	200 Network		
Deductible	N/A	$1,000 single / $2,000 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	25% coinsurance after deductible	
Out of Pocket Maximum	$6,350 single/$12,700 family	$5,000 single / $10,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	6/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	Birth date		
Domestic Partner and Children	Includes coverage for domestic partner and children		
Prescription Drug Coverage			
Prescription Drugs	$10/$50/$100	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Prescription Deductible	No		

	POS 206		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	$25 copayment	25% coinsurance after deductible	
Specialist Office Visit	$25 copayment	25% coinsurance after deductible	
Telemedicine	$25 copayment	Not covered	
Allergy Injections	$25 copayment/$25 copayment	25% coinsurance after deductible	
Allergy Testing	$25 copayment/$25 copayment	25% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$25 copayment	25% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	Covered in Full	25% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	$25 copayment	25% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$50 copayment	Covered as in-network	Copay waived if admitted.
Ambulance	$50 copayment	Covered as in-network	
Urgent Care Center	$35 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	25% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	25% coinsurance after deductible	
Immunizations	Covered in full	25% coinsurance after deductible	
Mammogram	Covered in full	25% coinsurance after deductible	
Pap Smear	Covered in full	25% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	25% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Well Child Visits	Covered in full	25% coinsurance after deductible	

	POS 206		
	In-Network	Out-of-Network	Additional Information
Hospital Services			
Inpatient Hospital	$500 per admission, not to exceed $500 single/$1,000 family	25% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	$75 copayment	25% coinsurance after deductible	Preauth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	$500 per admission, not to exceed $500 single/$1,000 family	25% coinsurance after deductible	50 Days
Diagnostic Testing Services			
Laboratory Tests	Covered in full	25% coinsurance after deductible	
Radiology	$25 copayment/$25 copayment	25% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment	25% coinsurance after deductible	
Inpatient Maternity	Covered in full	25% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	$500 per admission, not to exceed $500 single/$1,000 family	25% coinsurance after deductible	
Outpatient Mental Health	$25 copayment	25% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$500 per admission, not to exceed $500 single/$1,000 family	25% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$500 per admission, not to exceed $500 single/$1,000 family	25% coinsurance after deductible	
Outpatient Substance Abuse	$25 copayment	25% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	$25 copayment	25% coinsurance after deductible	
Insulin and Other Oral Agents	$25 copayment	25% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay
Diabetic Medical Supplies (Test strips, Syringes, etc)	$25 copayment	25% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$25 copayment	25% coinsurance after deductible	

	POS 206		
	In-Network	Out-of-Network	Additional Information
Rehabilitation Services			
Physical - Occupational - Speech Therapies	$25 copayment	25% coinsurance after deductible	20 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$25 copayment	25% coinsurance after deductible	24 visits per year within a 12 week period
Additional Services			
Chemotherapy - Outpatient Facility	$25 copayment	25% coinsurance after deductible	
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible	
Home Health Care	$25 copayment	25% coinsurance after deductible	No copay for early maternity discharge;unlimited in-net; max 365 agg all Home Care OON red by # rec in-net
Hospice	Covered in full	25% coinsurance after deductible	210 days per cal yr INN & OON aggregate
Prosthetics & orthotics	20% coinsurance	Not covered	
Dialysis	Covered in full	25% coinsurance after deductible	
Wellness Card	$250 allowance	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 covered	1 every year. All adults and children.
Medical Eye Exam	$25 copayment	25% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	1 every year. All adults and children.
Medical Eye Exam	$25 copayment	25% 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.