1-800-544-2583 **bcbswny.com**

Benefit Summary for Group:
Daemen College
Effective Date: 6/1/2019

	POS 8200		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	200 Network		
Deductible	$1,500/$3,000 Combined INN & OON Deductible	$1,500/$3,000 Combined INN & OON Deductible	
Deductible Administration Type	True Family Deductible-On family plans, any individual can incur up to the family deductible amount.	True Family Deductible-On family plans, any individual can incur up to the family deductible amount.	
Coinsurance	20% coinsurance after deductible	40% coinsurance after deductible	
Out of Pocket Maximum	$4,000 single / $8,000 family	$5,000 single / $10,000 family	
Out of Pocket Administration Type	Embedded Out of Pocket Maximum-On family plans, one person cannot exceed the individual out of pocket maximum amount	Embedded Out of Pocket Maximum-On family plans, one person cannot exceed the individual 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 after deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Prescription Deductible	Yes		

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	POS 8200		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	20% coinsurance after deductible	40% coinsurance after deductible	
Specialist Office Visit	20% coinsurance after deductible	40% coinsurance after deductible	
Telemedicine	20% coinsurance after deductible	40% coinsurance not subject to deductible	
Allergy Injections	20% coinsurance after deductible	40% coinsurance after deductible	
Allergy Testing	20% coinsurance after deductible	40% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	20% coinsurance after deductible	40% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	Covered in Full after deductible	40% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	20% coinsurance after deductible	40% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	20% coinsurance after deductible	Covered as in-network	Copay waived if admitted.
Ambulance	20% coinsurance after deductible	Covered as in-network	
Urgent Care Center	20% coinsurance after deductible	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full not subject to deductible	40% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	40% coinsurance after deductible	
Immunizations	Covered in full not subject to deductible	40% coinsurance after deductible	
Mammogram	Covered in full not subject to deductible	40% coinsurance after deductible	
Pap Smear	Covered in full not subject to deductible	40% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	40% coinsurance after deductible	
Routine Physical Exam	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	40% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible	

	POS 8200		
	In-Network	**Out-of-Network**	**Additional Information**
Hospital Services			
Outpatient Surgical Procedure (Facility)	20% coinsurance after deductible	40% coinsurance after deductible	Preauth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	20% coinsurance after deductible	40% coinsurance after deductible	60 Days
Diagnostic Testing Services			
Laboratory Tests	20% coinsurance after deductible	40% coinsurance after deductible	
Radiology	20% coinsurance after deductible	40% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	20% coinsurance after deductible	40% coinsurance after deductible	
Inpatient Maternity	20% coinsurance after deductible	40% coinsurance after deductible	Prior auth not required for routine maternity/newborn.
Mental Health and Substance Abuse			
Inpatient Mental Health	20% coinsurance after deductible	40% coinsurance after deductible	
Outpatient Mental Health	20% coinsurance after deductible	40% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	20% coinsurance after deductible	40% coinsurance after deductible	
Inpatient Substance Abuse - Detox	20% coinsurance after deductible	40% coinsurance after deductible	
Outpatient Substance Abuse	20% coinsurance after deductible	40% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	20% coinsurance after deductible	40% coinsurance after deductible	
Insulin and Other Oral Agents	20% coinsurance after deductible	40% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay
Diabetic Medical Supplies (Test strips, Syringes, etc)	20% coinsurance after deductible	40% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	20% coinsurance after deductible	40% coinsurance after deductible	
Physical - Occupational - Speech Therapies	20% coinsurance after deductible	40% coinsurance after deductible	30 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	20% coinsurance after deductible	40% coinsurance after deductible	24 visits per plan yr in a 12 week period. Aggregate IN + OON

	POS 8200		
	In-Network	**Out-of-Network**	**Additional Information**
Additional Services			
Chemotherapy - Outpatient Facility	20% coinsurance after deductible	40% coinsurance after deductible	
Durable Medical Equipment	20% coinsurance after deductible	40% coinsurance after deductible	
Home Health Care	20% coinsurance after deductible	40% coinsurance after deductible	365 Visits IN & OON
Hospice	20% coinsurance after deductible	40% coinsurance after deductible	Unlimited visits
Prosthetics & orthotics	20% coinsurance after deductible	40% coinsurance after deductible	
Dialysis	20% coinsurance after deductible	40% 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 subject to deductible	Not covered	1 every year. All adults and children.
Medical Eye Exam	20% coinsurance after deductible	40% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full not subject to deductible	Not covered	1 every year. All adults and children.
Medical Eye Exam	20% coinsurance after deductible	40% 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.