BlueCross and BlueShield of Western New York

Plan: POS 250D Select — Web Site: http://www.bcbswny.com
Group #00995459, 00995458

Monthly Employee Contributions: **EE Only = *$183*** **EE + 1 = *$374*** **Family = *$578***

Benefit	2019 Actives
Annual Deductible	$500 individual/$1,000 family (In-network); $2,000 individual/$4,000 family (Out-of-network)
Annual Out-of-pocket limit	$5,000 individual/$10,000 family (In-network); $10,000 individual/$20,000 family (Out-of-network)
Member coinsurance level	10% (In-network); 50% (Out-of-network)
Inpatient hospital	
Room and board	90% covered after deductible
Ancillary charges	90% covered after deductible
Special-duty nursing	Not covered
Skilled nursing facility	90% covered after deductible
Surgery	
Inpatient	90% covered after deductible
Outpatient	90% covered
Cosmetic	Covered when medically necessary
Maternity care	
Obstetrical visits	$20 first visit; covered in full thereafter
Hospitalization	90% covered
Outpatient	
Office visits	$20 copay/visit
Routine examinations	100% covered
X-rays and lab work	90% covered
Eye examinations	Covered in full every other year (includes dilated fundus evalution)
Eyeglasses	Discounts available on lenses and frames at participating providers
Physical therapy	90% covered /visit up to 30 visits/year (visit limit is combined with speech and occupational therapy visits)
Chiropractor	$20 copay/visit for medically necessary treatment only
Alcoholism and chemical dependency	
Detoxification	Inpatient: 90% covered after deductible Outpatient: 90% covered
Rehabilitation	Inpatient: 90% covered after deductible Outpatient: 90% covered
Mental Health	
Inpatient	90% covered after deductible
Outpatient	90% covered
Other Services	
Ambulance	90% covered after deductible
Hospice care	90% covered
Home health care	$20 copay/visit; 365 visit maximum out-of-network (unlimited in-network)
Durable medical equipment	Covered at 50%
Emergency room	
In-area/contract facility	90% covered after deductible; urgent care visit 90% covered
In-area/noncontract facility	90% covered after deductible
Out-of-area/noncontract facility	90% covered after deductible
Prescription Drug Coverage	*(provided by Express Scripts)*
Retail (generic; 30-day supply)	$10 copay (Generic oral contraceptives: Covered in full)
Retail (brand; 30-day supply)	$30 copay Formulary brand; $50 copay Nonformulary brand
Mail order (90-day supply)	$30 copay Generic; $90 copay Formulary brand; $150 copay Nonformulary brand