BlueCross and BlueShield of Western New York

Plan: POS 250D Select Active & Pre-65 Non-Medicare Web Site: http://www.bcbswny.com
Group #00995459, 00995458

Monthly Retiree Contributions: **EE/Retiree Only = *$185* EE/Retiree + SP = *$375* Family = *$580***

Benefit	2021 Retirees
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 stay	90% covered after deductible
Special-duty nursing	Not covered
Skilled nursing facility	90% covered after deductible (60 days maximum per year)
Surgery	
Inpatient	90% covered after deductible
Outpatient	90% covered, no deductible (may be subject to pre-authorization)
Cosmetic	Only covered when medically necessary (90%)
Maternity care	
Inpatient hospital maternity	90% covered, n deductible
Obstetrical visits	$20 first visit; covered in full thereafter
Outpatient	
Preventive Services	100% covered for eligible services, no deductible (See your benefit booklet for a complete list of covered services)
Office visits (Primary & Specialists)	$20 copay per visit
Routine examinations	100% covered, no deductible (one per year)
X-rays and lab work	90% covered, no deductible
Medical eye examinations	$20 copay, no deductible (one per year)
Vision Benefits See full vision benefits in booklet	Each year: one free vision exam, $100 frame allowance and lenses covered in full for first pair, $100 allowance on first purchase for contacts in lieu of glasses
Physical-Occupational-Speech therapies	90% covered per visit, up to 30 visits a year (visit limit is a combination of speech, physical and occupational therapy visits)
Chiropractor	$20 copay per visit
Alcoholism and chemical dependency	
Detoxification	Inpatient: 90% covered after deductible Outpatient: 90% covered, no deductible
Rehabilitation	Inpatient: 90% covered after deductible Outpatient: 90% covered, no deductible
Mental Health	
Inpatient	90% covered after deductible
Outpatient	90% covered, no deductible
Other Services	
Ambulance	90% covered after deductible
Hospice care	90% covered, no deductible (unlimited visits)
Home health care	$20 copay per visit; 40 visits per year
Durable medical equipment	Covered at 50%, no deductible
Emergency room & Urgent Care Services	
In-Network & Out-of-Network	90% covered after deductible
Urgent Care Center	90% covered, no deductible
Prescription Drug Coverage	*Not subject to deductible (provided through 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