
FIRST QUARTER 2018
SMALL GROUP
PRODUCT PORTFOLIO
BlueShield
of Northeastern New York
LIVE
FEARLESS

BlueShield
of Northeastern New York

Benefits of BlueShield

Innovative plan designs

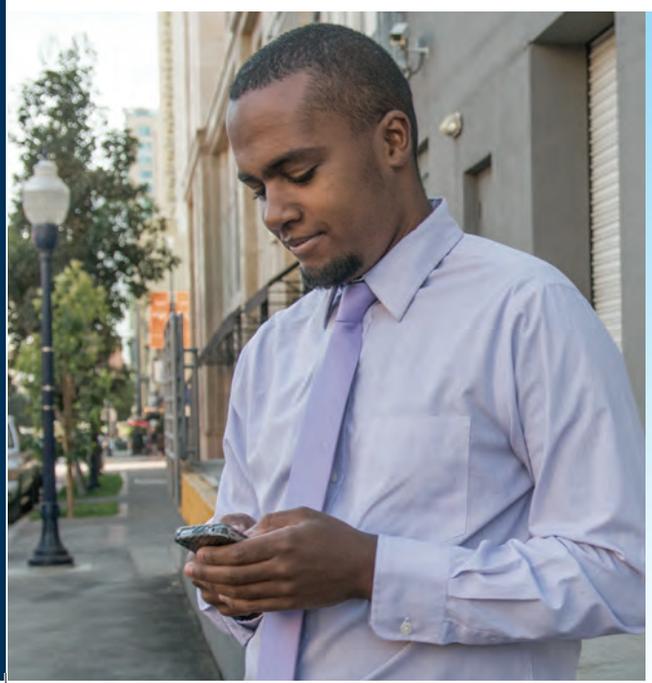
- **Expanded (EX) network plans**
  - Enhanced network access with POS locally and PPO for out-of-area
  - Available for employees who work or live in the BlueShield service area
- **National PPO plans offered at every metal level**

We have you covered

- **Blue Flex Services**
  - We offer integrated health reimbursement accounts (HRAs), flexible spending accounts (FSAs), and transit expense administration (TEA)
  - Provides a single point of contact for you and an improved, more seamless experience for your employees
- **Vision programs included with all medical plans**
- **Pediatric and adult dental plans available**

Health and wellness offerings

- **Telemedicine hosted by Doctor On Demand**
  - Connect with a doctor face-to-face via phone, tablet, or computer
- **HealthyLife Rewards**
  - Exclusive subscriber nutrition benefit — earn cash and rewards for shopping healthy
- **$250 wellness debit card with every plan**
- **Health assessment**
  - $25 for subscriber taking the health assessment, and an additional $25 when a covered spouse/domestic partner takes the health assessment
- **Preventive services**
  - $0 preventive drugs available on nonstandard HSA plans
  - More than 50 free checkups and preventive services



BlueConnect

A comprehensive online benefits solution

BlueConnect is an online health management platform that helps you manage costs while delivering benefits to your employees in a more efficient manner.

- Streamlined new group registration
- Easy enrollment and management
- Convenient auto-deductions through eBilling (never miss a payment)
- Real-time reporting

Better for your employee, easier for you, affordable for everyone.

Visit **bsneny.com/blueconnect** today.

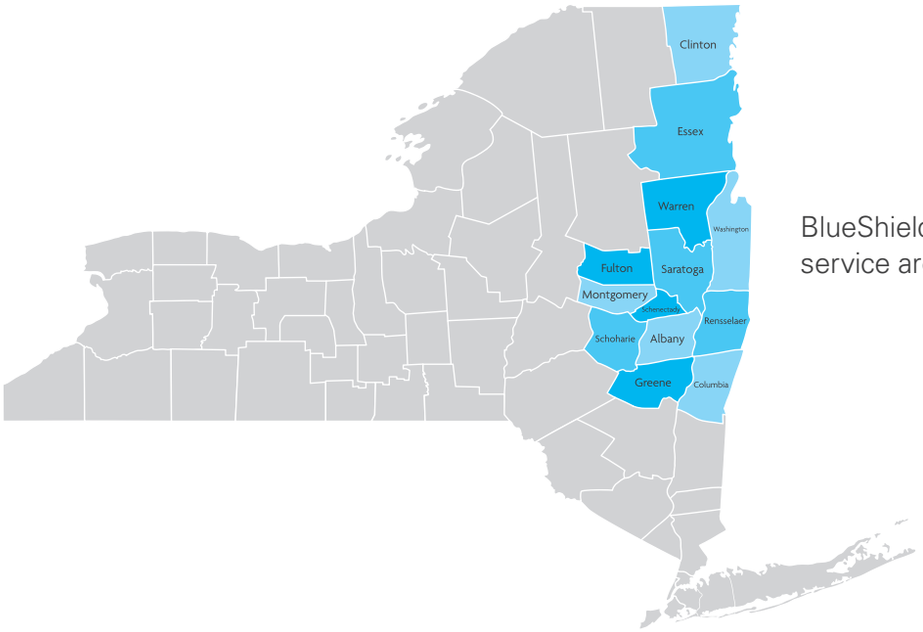
Your Network Options

At BlueShield of Northeastern New York, we offer a variety of diverse, expansive networks so that you can choose the coverage that best suits the needs of you and your employees.

	Health Maintenance Organization (HMO)	Point of Service (POS)
Network description	All health care services go through a primary doctor, who can also refer members to other health care professionals. Coordinating health care through a primary doctor means less paperwork and lower health care costs.	POS plans require members to choose a primary doctor in the BlueShield network, but they don't need referrals to visit other health care professionals.
Primary doctor required*	Yes	Yes
Referrals required	No	No
Out-of-network coverage	Yes	Yes
Emergency care covered as in-network	Yes	Yes
Good if you:	Don't travel	Travel sometimes

To find a doctor that participates with BlueShield, please visit **bsneny.com/findadoctor**.

* BlueShield of Northeastern New York's service area includes the following counties:
  Region 1: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.
  Region 7: Clinton and Essex



BlueShield's service area

Preferred Provider Organization (PPO)	Exclusive Provider Organization (EPO)	Expanded (EX) POS/PPO Wrap
PPO plans give members national in-network coverage and wide flexibility. In BlueShield's service area, members need to use a BlueShield participating provider for in-network coverage. Outside of the 13 counties shown above, members can use BlueCard for in-network coverage. If members use providers outside of the BlueShield or BlueCard networks, they'll have higher out-of-pocket costs (with the exception of emergency care).	EPO plans give members national in-network coverage. In BlueShield's service area, members need to use a BlueShield participating provider for in-network coverage. Outside of the 13 counties, members can use BlueCard for in-network coverage.	If members live and/or work within the BlueShield service area*, but are close to other counties and receive services in both areas, we offer our POS/PPO Wrap network. This network combines the best of POS and PPO networks; it offers an extensive variety of quality health care professionals both locally and across the country – and all at the same in-network cost.
No	No	Yes
No	No	No
Yes	No	Yes
Yes	Yes	Yes
Travel often or have family members living outside the area	Travel often or have family members living outside the area	Live in BlueShield's service area, but often receive services in a bordering state and/or county

Platinum

First Quarter 2018

Plan/market name	Platinum Standard	Platinum Radius*	Platinum EX	Platinum PPO
Network	**POS**	**POS**	**POS/PPO Wrap**	**PPO**
In-network				
Class ID	**2701**	**9301**	**9201**	**2801**
Deductible (single/family)	N/A	N/A	N/A	
Coinsurance	N/A	N/A	N/A	
Out-of-pocket maximum (single/family)	$2,000/$4,000 embedded	$5,000/$10,000 embedded	$5,000/$10,000 embedded	
Out-of-network				
Deductible (single/family)	$5,000/$10,000 embedded	$250/$500 embedded	$2,000/$4,000 embedded	
Coinsurance	50% after deductible	20% after deductible	20% after deductible	
Out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	$6,600/$13,200 embedded	$10,000/$20,000 embedded	
Medical services				
PCP/specialist	$15/$35	$0 pediatric PCP visits $0 for first three adult PCP visits $15/$20	$0 pediatric PCP visits $0 for first three adult PCP visits $15/$20	
Laboratory services	$35	$15	$15	
Diagnostic X-rays and radiology	$35	$20	$20	
Hospital services				
Inpatient hospital (per admission)	$500	$250	$250	
Outpatient facility	$100	$100	$100	
Emergency room visit	$100	$100	$100	
Urgent care	$55	$50	$50	
Prescription drugs				
Generic/formulary/non-formulary	$10/$30/$60	$10/$35/$70	$10/$35/$70	
Preventive drug list	No	No	No	
Pediatric vision				
Pediatric annual exam (routine)	$15	Covered in full	Covered in full	
Pediatric eyewear (including frames, lenses, contact lenses)†	10%	10%	10%	
HSA-eligible	No	No	No	
Creditable coverage	Yes	Yes	Yes	
Product name	**Platinum Standard**	**Platinum Radius**	**Platinum EX**	**Platinum PPO**
Region 1 Rates				
Subscriber	$695.38	$697.21	$725.80	$784.85
Subscriber and spouse/domestic partner	$1,390.76	$1,394.42	$1,451.60	$1,569.70
Subscriber and child(ren)	$1,182.15	$1,185.26	$1,233.87	$1,334.25
Family	$1,981.83	$1,987.05	$2,068.53	$2,236.83
Region 7 Rates				
Subscriber	$840.82	$843.07	$878.04	$950.29
Subscriber and spouse/domestic partner	$1,681.64	$1,686.14	$1,756.08	$1,900.58
Subscriber and child(ren)	$1,429.40	$1,433.22	$1,492.67	$1,615.49
Family	$2,396.33	$2,402.75	$2,502.41	$2,708.33

* Plan includes away from home care guest membership.

† Eyewear benefit administered by Davis Vision.

Gold

First Quarter 2018

Plan/market name	Gold Standard	Gold EPO high	Gold Radius high*	Gold EX high
Network	**POS**	**EPO**	**POS**	**POS/PPO Wrap**
In-network				
Class ID	**1101**	**2901**	**3101**	**6301**
Deductible (single/family)	$600/$1,200 embedded	N/A		
Coinsurance	N/A	N/A		
Out-of-pocket maximum (single/family)	$4,000/$8,000 embedded	$6,600/$13,200 embedded		
Out-of-network				
Deductible (single/family)	$5,000/$10,000 embedded	N/A	$250/$500 embedded	$2,000/$4,000 embedded
Coinsurance	50% after deductible	N/A	20% after deductible	20% after deductible
Out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	N/A	$6,600/$13,200 embedded	$10,000/$20,000 embedded
Medical services				
PCP/specialist	$25/$40 after deductible	$0 pediatric PCP visits $0 for first three adult PCP visits, $25/$40		
Laboratory services	$40 after deductible	$25		
Diagnostic X-rays and radiology	$40 after deductible	$40		
Hospital services				
Inpatient hospital (per admission)	$1,000 after deductible	$500	$750	$500
Outpatient facility	$100 after deductible	$200	$200	$200
Emergency room visit	$150 after deductible	$100	$200	$100
Urgent care	$60 after deductible	$75	$75	$75
Prescription drugs				
Generic/formulary/non-formulary	$10/$35/$70	$4/$35/$70		
Preventive drug list	No	No		
Pediatric vision				
Pediatric annual exam (routine)	$25 after deductible	Covered in full		
Pediatric eyewear (including frames, lenses, contact lenses) †	20% after deductible	20%		
HSA-eligible	No	No		
Creditable coverage	Yes	Yes		

Product name	Gold Standard	Gold EPO high	Gold Radius high	Gold EX high
Region 1 Rates				
Subscriber	$610.25	$701.81	$642.45	$670.68
Subscriber and spouse/domestic partner	$1,220.50	$1,403.62	$1,284.90	$1,341.36
Subscriber and child(ren)	$1,037.42	$1,193.08	$1,092.17	$1,140.15
Family	$1,739.21	$2,000.16	$1,830.98	$1,911.44
Region 7 Rates				
Subscriber	$736.68	$848.70	$776.07	$810.61
Subscriber and spouse/domestic partner	$1,473.36	$1,697.40	$1,552.14	$1,621.22
Subscriber and child(ren)	$1,252.36	$1,442.79	$1,319.32	$1,378.03
Family	$2,099.54	$2,418.80	$2,211.80	$2,310.24

* Plan includes away from home care guest membership.

† Eyewear benefit administered by Davis Vision.

	Gold HMO*	Gold PPO	Gold EPO	Gold Radius*	Gold EX
	HMO/POS	**PPO**	**EPO**	**POS**	**POS/PPO Wrap**
	3201	**6401**	**3301**	**3401**	**6501**
		$500/$1,000 embedded			
		20% after deductible			
		$7,200/$14,400 embedded			
ed	$5,000/$10,000 embedded	$5,000/$10,000 embedded	N/A	$500/$1,000 embedded	$5,000/$10,000 embedded
	20% after deductible	50% after deductible	N/A	20% after deductible	50% after deductible
ed	$10,000/$20,000 embedded	$10,000/$20,000 embedded	N/A	$7,200/$14,400 embedded	$10,000/$20,000 embedded
		$0 pediatric PCP visits, $25/$50			
		$25			
		20% after deductible			
	$1,000	20% after deductible			
	$200	20% after deductible			
	$200	$200			
	$75	$100			
		$4/$35/$70			
		No			
		Covered in full			
		20% after deductible			
		No			
		Yes			

	Gold HMO	Gold PPO	Gold EPO	Gold Radius	Gold EX
	$640.84	$664.08	$644.48	$595.22	$614.66
	$1,281.68	$1,328.16	$1,288.96	$1,190.44	$1,229.32
	$1,089.42	$1,128.94	$1,095.62	$1,011.88	$1,044.92
	$1,826.40	$1,892.63	$1,836.77	$1,696.38	$1,751.78
	$774.11	$802.55	$778.57	$718.31	$742.07
	$1,548.22	$1,605.10	$1,557.14	$1,436.62	$1,484.14
	$1,315.99	$1,364.34	$1,323.57	$1,221.13	$1,261.52
	$2,206.21	$2,287.26	$2,218.92	$2,047.18	$2,114.90

Silver

First Quarter 2018

Plan/market name	Silver Standard	Silver POS Hybrid	Silver EPO 6300	Silver PPO 8000	Silver EX 8000	Silver POS 8000	Silver EPO 8000
Network	**POS**	**POS**	**EPO**	**PPO**	**POS/PPO Wrap**	**POS**	**EPO**
In-network							
Class ID	**5601**	**9401**	**3801**	**6601**	**6801**	**6701**	**3601**
Deductible (single/family)	$2,000/$4,000 embedded	$6,350/$12,700 embedded	$1,350/$2,700 true family	$3,250/$6,500 embedded			
Coinsurance	N/A	20% after deductible	N/A	0% after deductible			
Out-of-pocket maximum (single/family)	$6,750/$13,500 embedded	$7,350/$14,700 embedded	$5,000/$10,000 embedded	$6,650/$13,300 embedded			
Out-of-network							
Deductible (single/family)	$5,000/$10,000 embedded	$6,350/$12,700 embedded	N/A	$5,000/$10,000 embedded			N/A
Coinsurance	50% after deductible	50% after deductible	N/A	50% after deductible			N/A
Out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	$10,000/$20,000 embedded	N/A	$10,000/$20,000 embedded			N/A
Medical services							
PCP/specialist	$30/$50 after deductible	$40/$60	$40/$60 after deductible	0% after deductible			
Laboratory services	$50 after deductible	$40	$40 after deductible	0% after deductible			
Diagnostic X-rays and radiology	$50 after deductible	20% after deductible	$60 after deductible	0% after deductible			
Hospital services							
Inpatient hospital (per admission)	$1,500 after deductible	20% after deductible	$500 after deductible	0% after deductible			
Outpatient facility	$100 after deductible	20% after deductible	$250 after deductible	0% after deductible			
Emergency room visit	$250 after deductible	$750	$250 after deductible	0% after deductible			
Urgent care	$70 after deductible	$100	$75 after deductible	0% after deductible			
Prescription drugs							
Generic/formulary/non-formulary	$10/$35/$70	$4/$50/$100	$4/$35/$70 after deductible	$10/$35/$70 after deductible			
Preventive drug list	No	No	Yes	Yes			
Pediatric vision							
Pediatric annual exam (routine)	$30 after deductible	Covered in full	Covered in full	Covered in full			
Pediatric eyewear (including frames, lenses, contact lenses) †	30% after deductible	30% after deductible	30% after deductible	0% after deductible			
HSA-eligible	No	No	Yes	Yes			
Creditable coverage	Yes	Yes	Yes	Yes			
Product name	**Silver Standard**	**Silver POS Hybrid**	**Silver EPO 6300**	**Silver PPO 8000**	**Silver EX 8000**	**Silver POS 8000**	**Silver EPO 8000**
Region 1 Rates							
Subscriber	$539.03	$546.59	$595.18	$604.19	$559.54	$536.93	$585.81
Subscriber and spouse/domestic partner	$1,078.06	$1,093.18	$1,190.36	$1,208.38	$1,119.08	$1,073.86	$1,171.62
Subscriber and child(ren)	$916.35	$929.20	$1,011.81	$1,027.13	$951.22	$912.78	$995.88
Family	$1,536.23	$1,557.79	$1,696.26	$1,721.94	$1,594.69	$1,530.25	$1,669.56
Region 7 Rates							
Subscriber	$649.58	$658.82	$718.26	$729.28	$674.66	$646.99	$706.80
Subscriber and spouse/domestic partner	$1,299.16	$1,317.64	$1,436.52	$1,458.56	$1,349.32	$1,293.98	$1,413.60
Subscriber and child(ren)	$1,104.29	$1,120.00	$1,221.04	$1,239.78	$1,146.92	$1,099.88	$1,201.56
Family	$1,851.31	$1,877.63	$2,047.04	$2,078.45	$1,922.78	$1,843.92	$2,014.38

* Plan includes away from home care guest membership.

† Eyewear benefit administered by Davis Vision.

Bronze

First Quarter 2018

Plan/market name	Bronze Standard	Bronze EPO 6300	Bronze PPO	Bronze Value
Network	**POS**	**EPO**	**PPO**	**POS**
In-network				
Class ID	**7001**	**9501**	**7101**	**4301**
Deductible (single/family)	$4,000/$8,000 embedded	$4,500/$9,000 embedded	$6,650/$13,300 embedded	
Coinsurance	50% after deductible	N/A	0% after deductible	
Out-of-pocket maximum (single/family)	$7,150/$14,300 embedded	$6,650/$13,300 embedded	$6,650/$13,300 embedded	
Out-of-network				
Deductible (single/family)	$5,000/$10,000 embedded	N/A	$7,000/$14,000 embedded	
Coinsurance	50% after deductible	N/A	50% after deductible	
Out-of-pocket maximum (single/family)	$10,000/$20,000 embedded	N/A	$10,000/$20,000 embedded	
Medical services				
PCP/specialist	50% after deductible	$40/$60 after deductible	0% after deductible	
Laboratory services	50% after deductible	$40 after deductible	0% after deductible	
Diagnostic X-rays and radiology	50% after deductible	$60 after deductible	0% after deductible	
Hospital services				
Inpatient hospital (per admission)	50% after deductible	$1,500 after deductible	0% after deductible	
Outpatient facility	50% after deductible	$750 after deductible	0% after deductible	
Emergency room visit	50% after deductible	$750 after deductible	0% after deductible	
Urgent care	50% after deductible	$75 after deductible	0% after deductible	
Prescription drugs				
Generic/formulary/non-formulary	$10/$35/$70 after deductible	$10/$50/$100 after deductible	0%/0%/0% after deductible	
Preventive drug list	No	Yes	Yes	
Pediatric vision				
Pediatric annual exam (routine)	50% after deductible	Covered in full	Covered in full	
Pediatric eyewear (including frames, lenses, contact lenses) †	50% after deductible	50% after deductible	0% after deductible	
HSA-eligible	No	Yes	Yes	
Creditable coverage	Yes	Yes	Yes	
Product name	**Bronze Standard**	**Bronze EPO 6300**	**Bronze PPO**	**Bronze Value**
Region 1 Rates				
Subscriber	$462.41	$522.61	$541.29	$481.59
Employee and spouse/domestic partner	$924.82	$1,045.22	$1,082.58	$963.18
Subscriber and child(ren)	$786.09	$888.44	$920.19	$818.70
Family	$1,317.87	$1,489.44	$1,542.68	$1,372.53
Region 7 Rates				
Subscriber	$555.82	$629.46	$652.34	$579.28
Subscriber and spouse/domestic partner	$1,111.64	$1,258.92	$1,304.68	$1,158.56
Subscriber and child(ren)	$944.90	$1,070.09	$1,108.98	$984.78
Family	$1,584.08	$1,793.96	$1,859.17	$1,650.95

* Plan includes away from home care guest membership.

† Eyewear benefit administered by Davis Vision.

Pediatric and Adult Dental Plans

Dental care is important to overall health. That's why our dental plans include essential benefits to ensure members receive complete oral health coverage through our own dental network. Blue Value dental plans have no participation requirements – add to your medical plan or purchase one separately. Groups can choose one Blue Value dental plan to offer their employees in addition to Blue Pediatric dental.

	Blue Pediatric Dental (PPO)	Blue Value Dental 1 (PPO)	Blue Value Dental 2 (PPO)	Blue Value Dental 3** (PPO)
Benefits	Children up to age 19 years	Adult/family*	Adult/family*	Adult/family*
Deductible (embedded)	N/A	$50 per member/ $150 family maximum	$50 per member/ $150 family maximum	$50 per member/ $150 family maximum
Annual benefit maximum	N/A	$750 per member per plan year	$1,250 per member per plan year	$1,500 per member per plan year
Out-of-pocket maximum	$350 per one child $700 for two or more children (per plan year)	N/A	N/A	N/A
Orthodontic lifetime maximum (pediatric and adult cosmetic, routine braces)	N/A	N/A	N/A	$1,000 per member per lifetime
Preventive/diagnostic (exams, cleaning, X-rays)	$20 copay	$0 copay	$0 copay	$0 copay
Basic restorative (fillings, extractions, periodontics, endodontics)	50% coinsurance	50% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Major dental (bridges, crowns, dentures)	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible	50% coinsurance after deductible
Orthodontics	50% coinsurance (medically necessary only, routine braces not covered), subject to out-of-pocket max	Not covered	Not covered	50% coinsurance (adult and pediatric cosmetic orthodontics); subject to lifetime max
Product name	**Blue Pediatric Dental (PPO)**	**Blue Value Dental 1 (PPO)**	**Blue Value Dental 2 (PPO)**	**Blue Value Dental 3** (PPO)**
Rates (Regions 1 and 7)				
Subscriber	$21.41 (per child)	$20.45	$27.33	$31.55
Subscriber and spouse/ domestic partner		$40.90	$54.66	$63.10
Subscriber and child(ren)		$53.87	$63.89	$72.60
Family		$83.77	$102.38	$116.82

Note: Members can receive dental services from a provider who does not participate in the BlueShield contracted network of providers. Out-of-network services are reimbursed at 100% of the in-network fee schedule and the non-participating provider may balance bill the member for the remainder.

* Blue Pediatric dental benefits and cost-sharing are included in all Blue Value dental plans. Adults and adult dependents, ages 19-26, are covered in Blue Value Dental plans.

** Blue Value Dental 3 includes coverage for children up to age 19 for medically necessary orthodontics subject to an out-of-pocket maximum (see Blue Pediatric Benefits) and cosmetic orthodontics (routine braces) subject to a lifetime maximum per member. Adults and adult dependents have coverage for cosmetic orthodontics (routine braces) subject to a lifetime maximum per member.

Adult Vision Discount Programs

BlueShield plan benefits include eye care services for pediatric members (under age 19) and adult members. Pediatric members are covered for essential health benefits, including routine eye exams, frames, and lenses under their medical plan.

Exam and eyewear discounts for adults vary depending on their medical plan. The chart below provides highlights of the adult vision discount programs.

Adult Vision Discount Programs	Vision Affinity Discount Program*	Vision Discount Program*
Available	**Non-standard medical plans**	**Standard medical plans**
Benefits	**Member cost**	**Discounted member cost**
Eye exam	$0 annual cost	15% off provider's usual and customary fees Routine exam or contact lens fitting
Frames	$40 for frames priced up to $70 retail $40 plus 10% off for frames priced over $70 retail	35% off provider's usual and customary fees
Standard plastic lenses (single vision, bifocal, trifocal, lenticular)	Member cost varies based on lenses	Discounted cost varies based on lenses
Lens options (for example, tint, UV and anti-reflective coating)	Member cost varies based on lens options	Discounted cost varies based on lens options
Contact lens materials		
Disposable	10% off retail prices	15% off provider's usual and customary fees
Conventional	20% off retail prices	15% off provider's usual and customary fees
Other add-ons and services		
Sunglasses, contact lens solutions, etc.	10–20% discount depending on provider	20% off provider's usual and customary fees
Laser vision correction (LASIK or PRK)**	Up to 25% off usual and customary fees or 5% off promotional price — whichever is lowest	Up to 25% off usual and customary fees or 5% off promotional price — whichever is lowest
Frequency		
Examination	Annual	Unlimited
Frames	Unlimited	
Lenses	Unlimited	
Contact lenses	Unlimited	

* Davis Vision, an independent company, administers vision programs on behalf of BlueShield of Northeastern New York. Members must receive services from a Davis Vision provider, and services out-of-network are not covered.

** For more information on the Laser Vision Correction Discount Program available through Davis Vision, call 1-855-502-2020.

Annual Benefit Limits

Habilitation (PT/OT/ST)
60 combined visits per condition, per plan year

Rehabilitation, outpatient (PT/OT/ST)
60 combined visits per condition, per plan year

Rehabilitation, inpatient (PT/OT/ST)
60 combined visits, per plan year

Home health care
40 visits per plan year

Hearing aids
Single purchase every three years

Hospice
210 days per plan year, five visits per plan year for family bereavement

Substance abuse, outpatient
Unlimited, 20 visits per plan year for family counseling

Skilled nursing facility[1]
Unlimited

For standard plans:
[1] 200 days per year

THE NAME TRUSTED
FOR OVER 70 YEARS.

bsneny.com

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