

Summary of Benefits for: Bethlehem Chamber of Commerce



BlueShield
of Northeastern New York
A Division of HealthNow New York Inc. An Independent
Licensee of the BlueCross BlueShield Association

Highlights of POS 250D Select 26/26 POS 250D Select - Option 2

Doctor's Visit

PCP Office visits	\$25
PCP Office visits for dependents under age 19	\$25
Well child visits and immunizations (to age 19)	Covered in full
Specialist visits	\$40
Routine physical	Covered in full
Allergy immunotherapy	\$40

Diagnostic Testing

Diagnostic X-rays	20%
Laboratory testing	20%
MRI	20%

Women's Services

Gynecological office visits (Routine)	Covered in full
Mammograms (Routine)	Covered in full
Maternity care (routine prenatal & post-natal care)	\$25 (applies to first visit only)
Inpatient maternity stay	20%
Pap smears (Routine)	Covered in full

Management and Treatment

Alcohol & substance abuse (outpatient)	Unlimited visits: 20% coinsurance
Cardiac rehabilitation (24 visits)	20%
Chemotherapy	20%
Radiation therapy	20%
Chiropractic care	\$40
Diabetic equipment & supplies	\$25
Durable medical equipment	50%
Mental health (outpatient)	Unlimited visits: 20% coinsurance
Physical, speech & occupational therapy (30 aggregate visits)	20%
Prosthetics & orthotic appliances	50%
Post-mastectomy prosthetics	20%

Hospital, Facility and Home Services

Alcohol & substance abuse (inpatient detox)	Unlimited days inpatient detoxification; 20% after deductible
Alcohol & substance abuse (inpatient rehab)	Unlimited days rehab; 20% after deductible
Emergency ambulance (medically necessary)	20% after deductible
Emergency room (waived if admitted to hospital)	20% after deductible
Home care (40 visits)	\$25
Hospice (unlimited)	20%
Hospital stay (semi-private room; non-maternity)	20% after deductible

Mental Health (inpatient hospital or facility stay)	Unlimited days; 20% after deductible
Skilled nursing facility (non-custodial)	Unlimited; 20% after deductible
Surgery (outpatient facility)	20%
Urgent care	20%

Dependent Coverage

Dependent/Student	26/26
Domestic partner	Covered

Extras

Routine Vision exam (1 every 2 yrs; 1 per yr for children under 14 with diagnosed refractive error)	Covered in full
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Prescription Drug Coverage

Prescription drug	\$15/\$50/50% with \$250 deductible per member
Mail order	Custom Home Delivery 2 Fills at Retail/MO=2.5 Copays per 90 Day Supply

Out-of-Pocket Expenses

Annual deductible	In-Network - \$1,000/\$2,000; Out-of-Network - \$2,000/\$4,000
Coinsurance	In-Network - 20%; Out-of-Network - 50%
Annual out-of-pocket maximum	In-Network - \$5,000/\$10,000; Out-of-Network - \$10,000/\$20,000
Annual maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Benefit Administration

Benefit administration	Calendar year
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- Family Deductible - No payments are made until the entire family deductible has been met.
- Deductible applies to Out-of-Pocket maximum and Out of Pocket max includes deductible, coinsurance and copays.
- Deductible on Rx applies per member to 2nd and 3rd tier only (if applicable)
- Triple Rx options with coinsurance on the 3rd tier will require at least the 2nd tier copay.
- This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.