

# Summary of Benefits for: New York Council of Nonprofits, Inc.



**BlueShield**

of Northeastern New York

A Division of HealthNow New York Inc. An Independent Licensee of the Blue Cross BlueShield Association

Highlights of HMO 200 Plus - 19/25 Small Grp  
HMO 206 Plus - \$25/\$25, \$10/\$40, \$20/\$30 Chamber only

**Option 1 \$25 PCP/\$25  
Specialist**

**Option 2 \$10 PCP/\$40  
Specialist**

**Option 3 \$20 PCP/\$30  
specialist**

## Doctor's Visit

	Option 1 \$25 PCP/\$25 Specialist	Option 2 \$10 PCP/\$40 Specialist	Option 3 \$20 PCP/\$30 specialist
PCP Office visits	\$25	\$10	\$20
PCP Office visits for dependents under age 19	Covered in full	Covered in full	Covered in full
Well child visits and immunizations (to age 19)	Covered in full	Covered in full	Covered in full
Specialist visits	\$25	\$40	\$30
Routine physical	\$25	\$10	\$20
Allergy immunotherapy	\$25	\$40	\$30

## Diagnostic Testing

	Option 1 \$25 PCP/\$25 Specialist	Option 2 \$10 PCP/\$40 Specialist	Option 3 \$20 PCP/\$30 specialist
Diagnostic X-rays	\$25	\$40	\$30
Laboratory testing	Covered in full	Covered in full	Covered in full
MRI	\$25	\$40	\$30

## Women's Services

	Option 1 \$25 PCP/\$25 Specialist	Option 2 \$10 PCP/\$40 Specialist	Option 3 \$20 PCP/\$30 specialist
Gynecological office visits	\$25	\$10	\$20
Mammograms (Routine)	Covered in full	Covered in full	Covered in full
Maternity care (routine prenatal & post-natal care)	Covered in full (after copay for initial visit)	Covered in full (after copay for initial visit)	Covered in full (after copay for initial visit)
Inpatient maternity stay	Covered in full	Covered in full	Covered in full
Pap smears (Routine)	Covered in full	Covered in full	Covered in full

## Management and Treatment

	Option 1 \$25 PCP/\$25 Specialist	Option 2 \$10 PCP/\$40 Specialist	Option 3 \$20 PCP/\$30 specialist
Alcohol & substance abuse (outpatient) 60 aggregate visits	\$25	\$30	\$30
Cardiac rehabilitation (24 visits)	\$25	\$40	\$30
Chemotherapy	\$25	\$30	\$30
Radiation therapy	\$25	\$40	\$30
Chiropractic care	\$25	\$40	\$30
Diabetic equipment & supplies	\$25	\$10	\$20
Durable medical equipment (\$1000 maximum)	50%	50%	50%
Mental health (outpatient) 20 visits per member per year	\$25	\$40	\$30
Physical, speech & occupational therapy (30 aggregate visits)	\$25	\$40	\$30
Prosthetics & orthotic appliances (\$1000 maximum)	50%	50%	50%
Post-mastectomy prosthetics	Covered in full	Covered in full	Covered in full

## Hospital, Facility and Home Services

	Option 1 \$25 PCP/\$25 Specialist	Option 2 \$10 PCP/\$40 Specialist	Option 3 \$20 PCP/\$30 specialist
Alcohol & substance abuse 7 days inpatient detoxification	\$250	\$250	\$250
Alcohol & substance abuse (inpatient rehab)	No inpatient rehab	No inpatient rehab	No inpatient rehab
Emergency ambulance (medically necessary)	\$100	\$100	\$100
Emergency room (copay waived if admitted to hospital)	\$100	\$100	\$100
Home care (40 visits)	\$25	\$30	\$30
Hospice (unlimited)	Covered in full	Covered in full	Covered in full
Hospital stay (semi-private room)	\$250	\$250	\$250

Mental Health (inpatient hospital or facility stay) 30 days per member per year	\$250	\$250	\$250
Skilled nursing facility (non-custodial) Unlimited	\$250	\$250	\$250
Surgery (outpatient facility)	\$150	\$150	\$150
Urgent care	\$25	\$35	\$30

### Dependent Coverage

Dependent/Student	19/25	19/25	19/25
Domestic partner	Covered	Covered	Covered

### Extras

Routine vision exam (Annual)	\$25	\$30	\$30
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### Prescription Drug Coverage

Prescription drug (\$0 copay for generic oral contraceptives)	\$15/\$50/50%	\$15/\$50/50%	\$15/\$50/50%
Mail order	Custom Home Delivery 2 Fills at Retail/MO=2.5 Copays per 90 Day Suppl	Custom Home Delivery 2 Fills at Retail/MO=2.5 Copays per 90 Day Suppl	Custom Home Delivery 2 Fills at Retail/MO=2.5 Copays per 90 Day Suppl

### Out-of-Pocket Expenses

Annual deductible - Out-of-network	\$1,000 Single/\$2,000 Family	\$1,000 Single/\$2,000 Family	\$1,000 Single/\$2,000 Family
Coinsurance - Out-of-network	30%	30%	30%
Annual out-of-pocket maximum - Out-of-network	\$5,000 single/\$10,000 family	\$5,000 single/\$10,000 family	\$5,000 single/\$10,000 family
Annual maximum benefit - Out-of-network	\$1,000,000	\$1,000,000	\$1,000,000
Lifetime maximum benefit - Out-of-network	Unlimited	Unlimited	Unlimited

### Benefit Administration

Benefit administration	Calendar year	Calendar year	Calendar year
Vermont Rider	Not Covered	Not Covered	Not Covered
Dental Coverage	1 exam & 1 cleaning per calendar year each with specialist copay.	1 exam & 1 cleaning per calendar year each with specialist copay.	1 exam & 1 cleaning per calendar year each with specialist copay.

- Out-of-network Family Deductible - No payments are made until the entire family deductible has been met.
- 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.