

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 Slate (POS 7100) - 19/25
Slate (POS 7100) - \$1500/\$3000 Chamber only

In-Network after Deductible

Doctor's Visit

PCP Office visits	Covered in full
PCP Office visits for dependents under age 19	Covered in full
Well child visits and immunizations (to age 19)	Covered in full
Specialist visits	Covered in full
Routine physical (In-network)	Covered in full
Allergy immunotherapy	Covered in full

Diagnostic Testing

Diagnostic X-rays	Covered in full
Laboratory testing	Covered in full
MRI	Covered in full

Women's Services

Gynecological office visits (routine)	Covered in full
Mammograms (Routine)	Covered in full
Maternity care (routine prenatal & post-natal care)	Covered in full
Inpatient maternity stay	Covered in full
Pap smears (Routine)	Covered in full

Management and Treatment

Alcohol & substance abuse (outpatient) 60 aggregate visits	Covered in full
Cardiac rehabilitation (24 visits)	Covered in full
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Chiropractic care	Covered in full
Diabetic equipment & supplies	Covered in full
Durable medical equipment (\$1000 maximum)	Covered in full
Mental health (outpatient) 20 visits per member per year	Covered in full
Physical, speech & occupational therapy (30 aggregate visits)	Covered in full
Prosthetics & orthotic appliances (\$1000 maximum)	Covered in full
Post-mastectomy prosthetics	Covered in full

Hospital, Facility and Home Services

Alcohol & substance abuse (inpatient detoxification) 7 days inpatient detoxification	Covered in full
Alcohol & substance abuse (inpatient rehab)	No inpatient rehab
Emergency ambulance (medically necessary)	Covered in full

Emergency room (copay waived if admitted to hospital)	Covered in full
Home care (40 visits)	Covered in full
Hospice (unlimited)	Covered in full
Hospital stay (semi-private room)	Covered in full
Mental Health (inpatient hospital or facility stay) 30 days per member per year	Covered in full
Skilled nursing facility (non-custodial) Unlimited	Covered in full
Surgery (outpatient facility)	Covered in full
Urgent care	Covered in full

Dependent Coverage

Dependent/Student	19/25
Domestic partner	Covered

Extras

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

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

Out-of-Pocket Expenses

Annual deductible (combined in and out-of-network)	\$1,500 single/\$3,000 family
Coinsurance	In-Network - None; Out-of-Network - 30%
Annual out-of-pocket maximum	In-Network - \$5,000/\$10,000; Out-of-Network - \$10,000/\$20,000
Annual maximum benefit	In-Network - Unlimited; Out-of-Network - Unlimited
Lifetime maximum benefit	Unlimited

Benefit Administration

Benefit administration	Calendar year
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- *Deductible Information The In-Network deductible applies to all in-network services except Routine Preventative Care.*
- *Routine Preventative Care Includes - (not subject to deductible)*
Abdominal Aortic Aneurysm Screening, Adult and Child Immunizations, Bone Mineral Density, Colonoscopy, Colorectal Cancer Screening, Mammogram, Ob/Gyn, Pap Smear, PSA Test, Routine Physical, Vision Exam, Well Child
- *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.*
- *Prescription Drug and Mail Order - Copay only applies after deductible has been met.*
- *This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.*