

Summary of Benefits for: Colonie Chamber of Commerce Inc.



BlueShield

of Northeastern New York

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

Highlights of Slate (POS 7100) - 26/26
POS 7100 - Option 2

In-Network Your Copay After Deductible

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	\$25
Routine physical (In-network)	Covered in full
Allergy immunotherapy	\$25

Diagnostic Testing

Diagnostic X-rays	\$25
Laboratory testing	\$25
MRI	\$25

Women's Services

Gynecological office visits (Routine)	Covered in full
Mammograms (Routine)	Covered in full
Maternity care (routine prenatal & post-natal care)	\$25
Inpatient maternity stay	\$500
Pap smears (Routine)	Covered in full

Management and Treatment

Alcohol & substance abuse (outpatient) Unlimited visits per member per year	\$25
Cardiac rehabilitation (24 visits)	\$25
Chemotherapy	\$25
Radiation therapy	\$25
Chiropractic care	\$25
Diabetic equipment & supplies	\$25
Durable medical equipment	50%
Mental health (outpatient) Unlimited visits (r)	\$25
Physical, speech & occupational therapy (30 aggregate visits)	\$25
Prosthetics & orthotic appliances	50%
Post-mastectomy prosthetics	Covered in full

Hospital, Facility and Home Services

Alcohol & substance abuse (inpatient detoxification) Unlimited days inpatient detoxification rider	\$500
Alcohol & substance abuse (inpatient rehab)	Unlimited days rehab: \$500 copay

Emergency ambulance (medically necessary)	\$50
Emergency room (copay waived if admitted to hospital)	\$50
Home care (40 visits)	\$25
Hospice (unlimited)	\$25
Hospital stay (semi-private room)	\$500
Mental Health (inpatient hospital or facility stay) Unlimited days (r)	\$500
Skilled nursing facility (non-custodial) Unlimited	\$500
Surgery (outpatient facility)	\$75
Urgent care	\$35

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 (\$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 Preventive Care.
- *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.*