Traditional Blue

BlueShield of Northeastern New York

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

City of Troy

PPO 898 - Class 0001

DEDUCTIBLES/MAXIMUMS	
In network deductible	N/A
In network coinsurance	N/A
In network out of pocket maximum	$6,350/$12,700
Out of network deductible	$200/$400/$600
Out of network coinsurance	20% after deductible
Out of network out of pocket maximum	$2,000/$4,000
Out of network annual maximum	Unlimited
Out of network lifetime maximum	Unlimited
Benefit administration	1/1 Calendar Year
Dependent age	26
Student age	26
Dependent/Student coverage ends	Birth date
Domestic partner	No
PRESCRIPTION DRUG	
Prescription copay	$1/$3/$3
Mail order copay per 90 day supply	$0 copay per 90 day supply
Mandatory mail order applies	No
Prescription deductible	No Deductible
PHYSICIAN SERVICES - Office	
Primary care physician copay/Telemedicine	$10
Specialist copay	$10
Pediatric visits for children up to age 19	$10
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	Covered in full
Chiropractic	$10
Laboratory services	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full
Annual routine physical - adult	Covered in full
Annual routine eye exam	Covered in full every 24 months
Pre & post natal care	Covered in full after initial primary care physician copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening Adult	Covered in full
immunizations	Covered in full
Flu shot	Covered in full
Bone mineral density	Covered in full
Colorectal cancer screening	Covered in full
Routine mammogram	Covered in full
Routine pap smear	Covered in full
Physical exam (under age 21)	Covered in full
PSA test	Covered in full
Routine eye exam (children under age 5)	Covered in full
HOSPITAL	
Inpatient hospital stay	Covered in full
Inpatient maternity stay	Covered in full
Inpatient physical rehab (60 days)	Covered in full
Outpatient surgery	Covered in full
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	Covered in full
Ambulance- ground	Covered in full
Ambulance- air	Covered in full
Urgent care centers	$10
MENTAL HEALTH & SUBSTANCE ABUSE	
Mental health (inpatient)	Covered in full
Mental health (outpatient)	Covered in full
Alcohol & substance abuse (inpatient detox)	Covered in full
Alcohol & substance abuse (inpatient rehab)	Covered in full
Alcohol & substance abuse (outpatient)	Covered in full

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DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	Covered in full
OTHER SERVICES	
Cardiac rehabilitation (24 visits)	$10
Chemotherapy	Covered in full
Dialysis	Covered in full
Durable medical equipment	Covered in full
Home care	Covered in full
Hospice	Covered in full
Physical, speech & occupational therapy (90 visits aggregate)	Covered in full
Post-mastectomy prosthetics	Covered in full
Prosthetic and orthotic appliances	Covered in full
Radiation therapy	Covered in full
Skilled nursing facility (120 days)	Covered in full

Class 0001