



1-800-888-1238

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BlueShield
of Northeastern New York

Benefit Summary for Group:

CASHIC-East Greenbush CSD

Effective Date: 7/1/2021

	PPO 815		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO Network		
Deductible	N/A	\$500 single / \$1,000 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	30% coinsurance after deductible	
Out of Pocket Maximum	\$4,500 single / \$9,000 family	\$2,500 single / \$5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Not covered		
Prescription Drug Coverage			
Prescription Drugs	\$10/\$30/\$50	Not Covered	
Mail Order	\$20/\$60/\$100 per 90 day supply	Not Covered	

A division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

	PPO 815		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	\$25 copayment	30% coinsurance after deductible	
Specialist Office Visit	\$25 copayment	30% coinsurance after deductible	
Telemedicine	\$25 copayment	Not covered	
Allergy Injections	Covered in full	30% coinsurance after deductible	
Allergy Testing	Covered in full	30% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	\$25 copayment/\$25 copayment	30% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	\$25 copayment	30% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	\$25 copayment	30% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	\$100 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; inpatient benefits now apply.
Ambulance	Covered in full	Covered as in-network	
Urgent Care Center	\$25 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	30% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	30% coinsurance after deductible	
Immunizations	Covered in full	30% coinsurance after deductible	
Mammogram	Covered in full	30% coinsurance after deductible	
Pap Smear	Covered in full	30% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	30% coinsurance after deductible	
Well Child Visits	Covered in full	30% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	

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Hospital Services			
Outpatient Surgical Procedure (Facility)	\$200 copayment	30% coinsurance after deductible	Prior auth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	120 Days
Diagnostic Testing Services			
Laboratory Tests	Covered in full	30% coinsurance after deductible	
Radiology	Covered in full	30% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	\$25 copayment/\$25 copayment	30% coinsurance after deductible	
Inpatient Maternity	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	
Outpatient Mental Health	Covered in full	30% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	
Inpatient Substance Abuse - Detox	\$250 per admission, not to exceed \$500 single/\$750 family	30% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	30% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	\$25 copayment	30% coinsurance after deductible	
Insulin and Other Oral Agents	\$25 copayment	30% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay.
Diabetic Medical Supplies (Test strips, Syringes, etc)	\$25 copayment	30% coinsurance after deductible	Not covered
Rehabilitation Services			
Chiropractic Care	\$25 copayment/\$25 copayment	30% coinsurance after deductible	
Physical - Occupational - Speech Therapies	\$25 copayment/\$25 copayment	30% coinsurance after deductible	60 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	\$25 copayment/\$25 copayment	30% coinsurance after deductible	

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Additional Services			
Chemotherapy - Outpatient Facility	\$25 copayment	30% coinsurance after deductible	
Durable Medical Equipment	Covered in full	30% coinsurance after deductible	
Home Health Care	\$25 copayment/\$25 copayment	30% coinsurance after deductible	100 Visits IN & OON
Hospice	Covered in full	30% coinsurance after deductible	210 days INN & OON
Prosthetics & orthotics	Covered in full	30% coinsurance after deductible	
Dialysis	\$25 copayment	30% coinsurance after deductible	
Wellness Card	Not covered	Not covered	
Pediatric Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	\$25 copayment/\$25 copayment	30% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	\$25 copayment/\$25 copayment	30% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

***This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.