Blue Shield of Northeastern New York

Plan Name: Traditional Blue 998

Benefit	Par Provider	Non-par Provider	Comments
Medical/Outpatient Benefits			
Physician Office Visit	$20 copay	80% coverage subject to deductible	
Chiropractic Services	80% coverage not subject to deductible for Par Providers; subject to deductible for Non-par Providers; unlimited visits when medically necessary		
Mental Health Outpatient	$20 copay	80% coverage subject to deductible	
Pre-admission Testing	100% FS[1] within 14 days of admission	?	
Surgery-Outpatient	$40 copay	?	Copay charged at a free-standing outpatient surgery center
Diagnostic X-rays	100% FS	100% FS	
MRIs-Prior authorization required	100% FS	100% FS	Call Blue Shield if no response to prior auth request in 5 business days
Laboratory Tests	100% FS	?	
Hemodialysis	100% FS	?	
Chemotherapy	100% FS	100% FS	
IV Therapy	100% FS	100% FS, Balance paid at 80% of UCR[2] subject to deductible	
Radiation Therapy	100% FS	100% FS	
Physical, Speech & Occupational Therapy	365 visits aggregate 100% FS	?	365 visits aggregate = total number of visits of the 3 types of therapy combined
Emergency Room Care	$40 copay	$40 copay	Copay waived if admitted
Urgent Care Center	$20 copay	80% coverage subject to deductible	
Preventive Care Benefits			
Routine Physical	100% FS	80% coverage subject to deductible	Applies to employee & spouse/domestic partner only
Well Child Care & Immunizations to Age 19	100% FS	100% FS, Balance paid at 80% of UCR subject to deductible	
Colonoscopy	100% FS	100% FS	Limited to enrollees age 45 and older or those with a family history of cancer
Mammogram	100% FS	100% FS, Balance paid at 80% of UCR subject to deductible	
Pap Smear	100% FS	100% FS, Balance paid at 80% of UCR subject to deductible	
Routine OB/GYN Exam	100% FS	80% UCR, subject to deductible	Limited to one examination per calendar year

[1] FS=Fee Schedule

[2] UCR=Usual and Customary Rate

Benefit	Par Provider	Non-par Provider	Comments
Adult Immunizations: Flu, Shingles, Tetanus, HPV	100% FS	80% UCR, subject to deductible	Shingles covered at age 55 and over
	Inpatient Hospital Services		
Hospital Services-Prior Authorization Required	100% FS	?	
Mental Health-Inpatient-Prior Authorization Required	100% FS	?	
Physical Rehabilitation-Inpatient- Prior Auth Required	100% FS when medically necessary as part of 365 day total	?	USW filed contract grievance on Prior Authorization Requirement
Alcohol & Substance Abuse-Inpatient- Prior Auth Required	100% FS Unlimited Days	?	USW filed contract grievance on Prior Authorization Requirement
Skilled Nursing Facility (Non-custodial Care) Prior Auth Required	100% FS-Unlimited days within 14 days of discharge	?	USW filed contract grievance on Prior Authorization Requirement
Maternity	100% FS	?	
Second Surgical Opinion	100% FS	?	
Surgical Assistant	100% FS	?	
Anesthesia	100% FS	?	
Other Benefits & Services			
Home Health Care	40 visits, 100% FS	100% FS	40 visits per calendar year
Alcohol & Substance Abuse-Outpatient Facility	100% FS	?	Unlimited visits
Hospice	210 days, 100% FS	100% FS	
Diabetic Equipment & Supplies	Equipment covered at 80% FS subject to deductible	Equipment covered at 80% UCR subject to deductible	Diabetic Supplies covered under Prescription Plan
Durable Medical Equipment	80% FS subject to deductible	80% UCR subject to deductible	
Prosthetics/Orthotics	80% FS subject to deductible	80% UCR subject to deductible	Shoe inserts not covered
Outpatient Private Duty Nurse & Visiting Nurse	80% FS subject to deductible	80% UCR subject to deductible	
Ambulance	100% FS	100% of charges	
Ambulette (Wheelchair Vans/Stretcher Vans)	80% FS subject to deductible?	?	
Annual Deductible	N/A	$100 individual/$200 family	Applies when you use a non-participating provider
Coinsurance	80% to Par Providers	80% to Non-par Providers	
Out of Pocket Maximum	$1,500 individual per calendar year $2,750 family aggregate per calendar year		Includes medical copays and coinsurance
Annual Maximum Benefit	No limit		
Dependents/Dom Partners	Dependents covered to age 26; actual birthday. Coverage available for domestic partners.		

Blue Shield of Northeastern New York

Dental Benefits

Plan Name: Traditional Blue Dental 1098[3]

Benefit	Par Dentist	Non-par Dentist	Comments/Services Included
Annual Maximum	$1,500 per person	$1,500 per person	Per calendar year for non-orthodontic services
Diagnostic & Preventive Services	100% FS	?	Oral examination Periapical X-rays Bitewing X-rays as required Prophylaxis Topical fluoride application under age 19 Panoramic Film/Full Mouth Series
Restorative Services	80% FS	?	Palliative emergency treatment Fillings of silver amalgam, silicate & plastic restorations Repair of dentures Endodontics including pulpotomy, pulp capping & root canal treatment Simple tooth extractions Anesthesia
Additional Basic Benefits *Treatment Plan Required*	80% FS	?	Inlays (not part of a bridge) Crowns (not part of a bridge) Space maintainers Apicoectomy Oral surgery consisting of fracture and dislocation treatment, diagnosis & treatment of cysts & abscessed surgical extractions & impactions
Prosthetic Benefits *Treatment Plan Required*	80% FS	?	Full & partial dentures Removable or fixed bridges (no more than once every 5 years)
Periodontic Benefits *Treatment Plan Required*	80% FS	?	Periodontic Examinations Gingival curettage Gingivectomy/gingivoplasty Osseous surgery Mucogingivo plastic surgery Oral lesions
Orthodontic Benefits *Treatment Plan Required*	50% FS	?	Orthodontic services for dependent children up to age 19

6/16/16

[3] In addition to coinsurance, the enrollee can be balance billed for charges that exceed the dental schedule of allowances.