healthy changes everything.℠

BlueShield of Northeastern New York

IBEW Local 236 Health Benefit Fund

Traditional Blue EPO 5098

Only in network services are covered under this contract.

DEDUCTIBLES/MAXIMUMS	
In network deductible	None
In network coinsurance	None
In network out of pocket maximum	$3,300/ $6,600
Out of pocket administration type	Embedded - On family plans, one person cannot exceed the individual out of pocket maximum amount.
Out of network deductible	n/a
Out of network coinsurance	n/a
Out of network out of pocket maximum	n/a
Out of network annual maximum	n/a
Out of network lifetime maximum	n/a
Benefit administration	Calendar year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of Month
Domestic partner	No coverage for domestic partner
PRESCRIPTION DRUG	
Prescription copay	n/a
Mail order copay per 90 day supply	n/a
Mandatory mail order applies	n/a
Prescription deductible	n/a
PHYSICIAN SERVICES - Office	
Primary care physician copay	$25
Specialist copay	$25
Pediatric visits for children up to age 19	$25
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	$25
Chiropractic	$25
Laboratory services	$25
Radiology (x-ray, MRI, CT & other high tech imaging)	$25
Pre & post natal care	Covered in full after initial $25 copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening	Covered in full
Adult immunizations	Covered in full
Flu shot	Covered in full
Bone mineral density	Covered in full
Colorectal cancer screening	Covered in full
Colonoscopy	Covered in full
Routine mammogram	Covered in full
OB/GYN	Covered in full
Routine pap smear	Covered in full
Physical exam	Covered in full
PSA test	Covered in full
Routine eye exam (every other year)	Covered in full
HOSPITAL	
Inpatient hospital stay	$250
Inpatient maternity stay	$250
Inpatient physical rehabilitation (60 days)	$250
Outpatient surgery	$25
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	$50
Ambulance - ground ambulance	$50
Ambulance - air ambulance	$50
Urgent care centers	$25
MENTAL HEALTH & SUBSTANCE ABUSE	
Mental health (inpatient)	$250
Mental health (outpatient)	$25
Alcohol & substance abuse (inpatient detox)	$250
Alcohol & substance abuse (inpatient rehab)	$250
Alcohol & substance abuse (outpatient)	$25

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DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$25
OTHER SERVICES	
Cardiac rehabilitation (24 visits)	$25
Chemotherapy	$25
Dialysis	$25
Durable medical equipment	20% copay
Home care (200 visits)	$25
Hospice	$25
Physical, speech & occupational therapy (60 visits aggregate)	$25
Post-mastectomy prosthetics	Covered in full
Prosthetic and orthotic appliances	20% copay
Radiation therapy	$25
Skilled nursing facility (120 days)	$250

***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.