BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary:

Effective on or after 1/1/2021

	NENY Gold Ascend (2021)			
Class ID: 0101	**Optimum Choice Cost Share**	**Flexible Choice Cost Share**	**Non-Participating Cost Share**	**Additional Information**
General Information				
Provider Network	200 Network			
Deductible	N/A	$2,000 single / $4,000 family	Not covered	
Deductible Administration Type	N/A	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	Not covered	
Coinsurance	N/A	50% coinsurance after deductible	Not covered	
Out of Pocket Maximum	$7,900 single / $15,800 family combined with Flexible Choice	$7,900 single / $15,800 family combined with Optimum Choice	Not covered	
Out of Pocket Administration Type	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Not Covered	
Benefit Administration Date	Plan year			
Dependent Coverage				
Dependent Age	26/26			
Dependent Coverage Ends	End of birth month			
Domestic Partner and Children	Includes coverage for domestic partner and children			

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Prescription Drug Coverage				
Prescription Drugs	$0/$50/$80	N/A	N/A	
Mail Order	2.5 copays per 90 day supply	Not Covered	Not Covered	
Is Rx subject to Medical Deductible?	No			
Physician and Other Services				
Primary Office Visit	$0 copayment	50% coinsurance after deductible	Not covered	
Specialist Office Visit	$50 copayment	50% coinsurance after deductible	Not covered	
Telemedicine	Covered in full	Not covered	Not covered	
Allergy Injections	$0 copayment/$50 copayment	50% coinsurance after deductible	Not covered	
Allergy Testing	$0 copayment/$50 copayment	50% coinsurance after deductible	Not covered	
Outpatient Surgical Procedures (in physician's office)	$0 copayment/$50 copayment	50% coinsurance after deductible	Not covered	
Emergency and Urgent Care Services				
Emergency Room	$500 copayment	Covered as Optimum Choice	Covered as Optimum Choice	Cost-share waived if admitted
Ambulance	$500 copayment	Covered as Optimum Choice	Covered as Optimum Choice	
Urgent Care Center	$100 copayment	$100 copayment not subject to deductible	Covered as Optimum Choice	
Preventive Services				
Bone mineral density measurement or test	Covered in full	Covered in full not subject to deductible	Not covered	
Cholesterol Test (lipid panel)	Covered in full	Covered in full not subject to deductible	Not covered	
Immunizations	Covered in full	Covered in full not subject to deductible	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	Covered in full not subject to deductible	Not covered	
Routine Physical Exam	Covered in full	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full	Covered in full not subject to deductible	Not covered	

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Hospital Services				
Inpatient Hospital	$1,500 copayment	50% coinsurance after deductible	Not covered	
Outpatient Surgical Procedure (Facility)	$250 copayment	50% coinsurance after deductible	Not covered	
Skilled Nursing Facility	$1,500 copayment	50% coinsurance after deductible	Not covered	
Diagnostic Testing Services				
Laboratory Tests	Covered in full	50% coinsurance after deductible	Not covered	
Radiology	$50 copayment	50% coinsurance after deductible	Not covered	
Maternity Services				
Physician Services: Prenatal and Postnatal Care (initial visit)	Covered in full	50% coinsurance after deductible	Not covered	
Inpatient Maternity	$1,500 copayment	50% coinsurance after deductible	Not covered	
Mental Health and Substance Abuse				
Inpatient Mental Health	$1,500 copayment	50% coinsurance after deductible	Not covered	
Outpatient Mental Health	Covered in full	50% coinsurance after deductible	Not covered	
Inpatient Substance Abuse - Rehab	$1,500 copayment	50% coinsurance after deductible	Not covered	
Inpatient Substance Abuse - Detox	$1,500 copayment	50% coinsurance after deductible	Not covered	
Outpatient Substance Abuse	Covered in full	50% coinsurance after deductible	Not covered	Up to 20 visits a year may be used for family counseling
Diabetic Supplies and Services				
Diabetic Equipment	Covered in full	50% coinsurance after deductible	Not covered	Additional benefits available through Livongo.
Insulin and Other Oral Agents	Covered in full	50% coinsurance after deductible	Not covered	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. Diabetic drugs rendered at pharmacy are only covered in-network.
Diabetic Medical Supplies (Test strips, Syringes, etc)	Covered in full	50% coinsurance after deductible	Not covered	Additional benefits available through Livongo.

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Rehabilitation Services				
Chiropractic Care	Covered in full	50% coinsurance after deductible	Not covered	
Physical - Occupational - Speech Therapies	Covered in full	50% coinsurance after deductible	Not covered	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	$50 copayment	50% coinsurance after deductible	Not covered	
Additional Services				
Chemotherapy - Outpatient Facility	$0 copayment/$50 copayment	50% coinsurance after deductible	Not covered	
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible	Not covered	
Home Health Care	$50 copayment	50% coinsurance after deductible	Not covered	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
Hospice	$50 copayment	50% coinsurance after deductible	Not covered	210 days per year
Prosthetics and orthotics	50% coinsurance	50% coinsurance after deductible	Not covered	Shoe orthotics not covered. For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Dialysis	$0 copayment/$50 copayment	50% coinsurance after deductible	Not covered	
Wellness Card	$250 per contract	N/A	N/A	Benefit allowance accessible through use of debit card at participating providers for gym membership, massage, acupuncture, health food stores, chiropractic visits, etc
Pediatric Vision Services				
Routine Exam	Covered in full	Covered in full not subject to deductible	Not covered	One routine exam every calendar year; coverage up to Age 19
Medical Eye Exam	$50 copayment	50% coinsurance after deductible	Not covered	

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Adult Vision Services				
Routine Exam	Covered in full	Covered in full not subject to deductible	Not covered	One routine exam every calendar year
Medical Eye Exam	$50 copayment	50% coinsurance after deductible	Not covered	

*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.