



1-800-888-1238

bsneny.com

BlueShield
of Northeastern New York

Benefit Summary for Group:

Roman Catholic Diocese of Albany Lay Employees

Effective Date: 1/1/2020

	NENY HMO 206 Plus		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	200 Plus Network		
Deductible	N/A	\$500 single / \$1,000 family	
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	
Coinsurance	N/A	30% coinsurance after deductible	
Out of Pocket Maximum	\$6,350 single/\$12,700 family	\$5,000 single / \$10,000 family	
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.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	Actual Birthday		
Domestic Partner and Children	Not covered		
Prescription Drug Coverage			
Prescription Drugs	\$10/\$30/\$50	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx subject to Medical Deductible?	No		

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Physician and Other Services			
Primary Office Visit	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	
Specialist Office Visit	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Allergy Injections	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Allergy Testing	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	\$25/\$25 or \$10/\$40 or \$20/\$30	30% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	Covered in full	30% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	\$100 copayment	Covered as in-network	Copay waived if admitted.
Ambulance	\$100 copayment	Covered as in-network	
Urgent Care Center	\$25 or \$35 or \$30 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	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	30% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Well Child Visits	Covered in full	30% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	\$500 copayment	30% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	\$75 copayment	30% coinsurance after deductible	
Skilled Nursing Facility	\$500 copayment	30% coinsurance after deductible	Unlimited Days
Diagnostic Testing Services			
Laboratory Tests	Covered in full	30% coinsurance after deductible	
Radiology	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	

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Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	\$25/\$25 or \$10/\$40 or \$20/\$30	30% coinsurance after deductible	
Inpatient Maternity	Covered in full	30% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	\$500 copayment	30% coinsurance after deductible	
Outpatient Mental Health	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	\$500 copayment	30% coinsurance after deductible	
Inpatient Substance Abuse - Detox	\$500 copayment	30% coinsurance after deductible	
Outpatient Substance Abuse	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	
Insulin and Other Oral Agents	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	Copay is lesser of PCP or Rx copay.Copay per item.
Diabetic Medical Supplies (Test strips, Syringes, etc)	\$25 or \$10 or \$20 copayment	30% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Physical - Occupational - Speech Therapies	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	30 aggregate PT/OT/ST visits per year
Pulmonary Rehabilitation	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Additional Services			
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible	
Prosthetics and Appliances	50% coinsurance	50% coinsurance after deductible	
Home Health Care	\$25 or \$30 or \$30 copayment	30% coinsurance after deductible	40 visits/cal yr
Hospice	Covered in full	30% coinsurance after deductible	
Chemotherapy - Outpatient Facility	\$25 or \$30 or \$30 copayment	30% coinsurance after deductible	
Dialysis	\$25 or \$30 or \$30 copayment	30% coinsurance after deductible	
Wellness Card	N/A	N/A	

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Pediatric Vision Services			
Routine Exam	Covered in full	Not covered	1 every other year. 1 per year for under 14 with diagnosed refractive error.
Medical Eye Exam	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	1 every other year. 1 per year for under 14 with diagnosed refractive error.
Medical Eye Exam	\$25 or \$40 or \$30 copayment	30% coinsurance after deductible	

*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