BlueShield of Northeastern New York
30 Century Hill Drive • Latham, New York 12110
1-800-888-1238 bsneny.com

Benefit Summary for Group:
Roman Catholic Diocese of Albany Lay Employees
Effective Date: 1/1/2018

	HMO 206 Plus - 26/26		
	Option 1 $25 PCP/$25 Specialist	Option 2 $10 PCP/$40 Specialist	Option 3 $20 PCP/$30 specialist
General Information			
Annual deductible	$500 single/$1,000 family - Out-of-Network	$500 single/$1,000 family - Out-of-Network	$500 single/$1,000 family - Out-of-Network
Coinsurance	30% - Out-of-network	30% - Out-of-network	30% - Out-of-network
Annual out-of-pocket maximum	$6,350/$12,700 (IN),$5,000/ $10,000 (OON)	$6,350/$12,700 (IN),$5,000/ $10,000 (OON)	$6,350/$12,700 (IN),$5,000/ $10,000 (OON)
Benefit administration	Calendar year	Calendar year	Calendar year
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and sigmoidoscopy Immunizations Mammogram Pap smear Routine Physical exam Prenatal and one postpartum visit Prostate test (Prostate Specific Antigen "PSA") Well child visit Well woman visit	Covered in full	Covered in full	Covered in full
Routine vision exam (1 every 2 years;1 per yr for children under 14 with diagnosed refractive error)	Covered in full	Covered in full	Covered in full
Physician and Other Services			
PCP office visit	$25	$10	$20
Specialist office visit	$25	$40	$30
Allergy immunotherapy	$25	$40	$30
Emergency and Urgent Care Services			
Emergency room (waived if admitted to hospital)	$100	$100	$100
Emergency ambulance (medically necessary)	$100	$100	$100
Urgent care	$25	$35	$30

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Hospital Services			
Hospital stay (semi-private room; non-maternity)	$500	$500	$500
Surgery (outpatient)	$75	$75	$75
Skilled nursing facility (non custodial) - copay amount	$500	$500	$500
Skilled nursing facility (non custodial) - coverage limitations	Unlimited	Unlimited	Unlimited
Laboratory testing	Covered in full	Covered in full	Covered in full
Diagnostic x-rays	$25	$40	$30
MRI, CT & other imaging	$25	$40	$30
Maternity care (routine prenatal & post-natal care)	Covered in full (after copay for initial visit)	Covered in full (after copay for initial visit)	Covered in full (after copay for initial visit)
Inpatient maternity stay	Covered in full	Covered in full	Covered in full
Mental Health and Substance Abuse			
Mental health (inpatient hospital or facility stay) - copay amount	$500	$500	$500
Mental health (inpatient hospital or facility stay) - coverage limitation	Unlimited visits per member per year	Unlimited visits per member per year	Unlimited visits per member per year
Mental health (outpatient)	Unlimited visits per member per year; $25 copay	Unlimited visits per member per year; $40 copay	Unlimited visits per member per year; $30 copay
Alcohol & substance abuse (inpatient detox) - copay amount	$500	$500	$500
Alcohol & substance abuse (inpatient detox) - coverage limitation	Unlimited days	Unlimited days	Unlimited days
Alcohol & substance abuse (inpatient rehab) - copay amount	$500	$500	$500
Alcohol & substance abuse (inpatient rehab) - coverage limitation	Unlimited days	Unlimited days	Unlimited days

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Mental Health and Substance Abuse			
Alcohol & substance abuse (outpatient)	Unlimited visits per member per year; $25 copay	Unlimited visits per member per year; $30 copay	Unlimited visits per member per year; $30 copay
Diabetic Supplies and Services			
Diabetic equipment & supplies	$25	$10	$20
Chiropractic care	$25	$40	$30
Physical, speech & occupational therapy	$25 - 30 visits	$40 - 30 visits	$30 - 30 visits
Cardiac rehabilitation	$25	$40	$30
Additional Services			
Chemotherapy	$25	$30	$30
Radiation therapy	$25	$40	$30
Dental coverage	1 routine exam and cleaning every six months with specialist copay	1 routine exam and cleaning every six months with specialist copay	1 routine exam and cleaning every six months with specialist copay
Dialysis	$25	$30	$30
Home care	$25 - 40 visits	$30 - 40 visits	$30 - 40 visits
Hospice	Covered in full - unlimited	Covered in full - unlimited	Covered in full - unlimited
Durable medical equipment	50%	50%	50%
Prosthetic devices	50%	50%	50%
Post-mastectomy prosthetics	Covered in full	Covered in full	Covered in full
Prescription Drug Coverage			
Prescription drug	$10/$30/$50	$10/$30/$50	$10/$30/$50
Mail order	2.5 copay - 90 day supply	2.5 copay - 90 day supply	2.5 copay - 90 day supply
Dependent age	26/26	26/26	26/26
Domestic partner	Not Covered	Not Covered	Not Covered

This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.