BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

## Benefit Summary for Group:

## Roman Catholic Diocese of Albany Lay Employees

## Effective Date: 1/1/2019

| | 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 | $25 or $10 or $20 copayment | 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 $40 or $30 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 $30 or $30 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