Coverage Highlights 

With Community Blue, you choose the option that's right for you

With Community Blue HMO 206 Plus you'll enjoy:

- ***$0 copay*** for PCP pediatric primary care visits
- ***$0 copay*** for inpatient maternity stay
- ***$0 copay*** for generic formulary contraceptives
- ***No referrals needed*** when using an in-network specialist
- ***Over 2,900 physicians and health care providers*** to choose from
- Your ***choice of copays*** for doctor visits
- ***Worldwide coverage*** for emergency and urgent care
- ***Guest Memberships*** that enable members on extended business trips or vacation or family members away at school to join a nearby Blue HMO
- Innovative wellness and health ***management programs***
- The ability to **see doctors outside the network**
- **Vision benefits**, including free eyeglass lenses

Community Blue HMO 206 Plus offers you out-of-network coverage that gives you the flexibility of seeing any doctor – regardless of whether or not he or she participates in the Community Blue network.

For services you receive outside the network, you will be responsible for an annual deductible and coinsurance. You may have an additional payment responsibility if services are rendered by a non-participating provider. Any additional charges will not apply to your out-of-pocket maximum.

Benefit Summary

Albany-Colonie Regional Chamber of Commerce

Community Blue HMO 206 Plus	Your copayment choices are: PCP/Specialist $25/$25	PCP/Specialist $10/$40	PCP/Specialist $20/$30
Doctor Visits			
PCP Office Visits	$25	$10	$20
PCP Office Visits for Dependents Under Age 19	Covered in Full	Covered in Full	Covered in Full
Specialist Visits	$25	$40	$30
Routine Physicals	$25	$10	$20
Well Child Visits & Immunizations (up to age 19)	Covered in Full	Covered in Full	Covered in Full
Allergy Immunotherapy	$25	$40	$30
Diagnostic Testing			
Diagnostic X-rays	Covered in Full	Covered in Full	Covered in Full
Laboratory Testing	Covered in Full	Covered in Full	Covered in Full
MRI	Covered in Full	Covered in Full	Covered in Full
Women's Services			
Gynecological Office Visits	$25	$10	$20
Mammograms	Covered in Full	Covered in Full	Covered in Full
Maternity Care (prenatal & post-natal care)	Covered in Full (PCP copay for initial visit)	Covered in Full (PCP copay for initial visit)	Covered in Full (PCP copay for initial visit)
Inpatient Maternity Stay	Covered in Full	Covered in Full	Covered in Full
Pap Smears	Covered in Full	Covered in Full	Covered in Full
Management and Treatment			
Alcohol & Substance Abuse (outpatient) 60 visits per member per calendar year	$25	$40	$30
Cardiac Rehabilitation (24 visits per year)	$25	$40	$30
Chemotherapy, Radiation, Hemodialysis	$25	$40	$30
Chiropractic Care	$10	$10	$10
Diabetic Equipment & Supplies (glucagon, insulin and blood sugar pills RX copay, if less)	$25	$10	$20
Durable Medical Equipment ($1,000 per member per calendar year)	50%	50%	50%
Mental Health (outpatient) visits are per member per calendar year	Visits 1-20 = 50%	Visits 1-20 = 50%	Visits 1-20 = 50%
Occupational, Speech & Physical Therapy (Occupational & Speech Therapy - 20 visits aggregate, Physical Therapy - 20 visits per condition)	$25	$40	$30
Prosthetic & Orthotic Appliances ($1,000 per member per calendar year)	50%	50%	50%
Post-Mastectomy Prosthetic	Covered in Full	Covered in Full	Covered in Full

Benefit Summary

Albany-Colonie Regional Chamber of Commerce

Community Blue HMO 206 Plus	Your copayment choices are: PCP/Specialist $25/$25	PCP/Specialist $10/$40	PCP/Specialist $20/$30
Hospital, Facility and Home Services			
Alcohol & Substance Abuse (inpatient) 30 days detox	$500/$1,000	$500/$1,000	$500/$1,000
Emergency			
Ambulance (medically necessary)	$100	$100	$100
Emergency Room (copay waived if admitted to hospital)	$100	$100	$100
Home Care (365 aggregate visits per calendar year)	Covered in Full	Covered in Full	Covered in Full
Hospice (Unlimited days)	Covered in Full	Covered in Full	Covered in Full
Hospital Stay (semi-private room)	$500/$1,000	$500/$1,000	$500/$1,000
Mental Health (inpatient hospital or facility stay) 30 days per member per calendar year	$500/$1,000	$500/$1,000	$500/$1,000
Skilled Nursing Facility (non-custodial) Unlimited days	$500/$1,000	$500/$1,000	$500/$1,000
Surgery (outpatient facility)	$75	$75	$75
Urgent Care	$25	$10	$20
Dependent Coverage			
Dependent/Student Age to	19/25	19/25	19/25
Coverage is available for eligible domestic partner			
Extras			
Vision Exam Please refer to the vision benefits page of this book for additional information	$25	$30	$30
Dental Exam & Cleaning (annual benefit for each family member)	$25	$40	$30
Out-of-Network			
Annual Deductible	$1,000/$2,000	$1,000/$2,000	$1,000/$2,000
Coinsurance	30%	30%	30%
Annual Out-of-Pocket Maximum Per Member	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Annual Maximum Benefit	$250,000	$250,000	$250,000

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. A complete contract or group plan will be issued upon enrollment. Please check the contract or group plan for final information on your benefits and exclusions.

Prescription Drugs

Prescription Drug	Best Value — Formulary Generic Drug	More Choice More Cost — Formulary Brand Name Drug	Most Choice Most Expensive — Non-Formulary Generic & Brand Name Drug	Limits and Requirements
Pharmacy Costs*	$15	$50	50%	Up to a 30 calendar day supply of drugs is provided on each occasion the prescription is filled or refilled.
Mail Order Costs*	$15	$50	50%	Custom Home Delivery 2 Fills at Retail/mo = 2.5 copays per 90 day supply Up to a 90 calendar day supply of drugs is provided on each occasion the prescription is filled or refilled

*Prescription Drug and Mail Order - Copay only applies once deductible has been met.
Prescription Drug - For options with 50% in the 3rd tier, there is a minimum member responsibility of 2nd tier copay.

How can I reduce my prescription costs?

Your pharmacy benefit offers you the flexibility of choosing generic or brand name drugs. You can significantly reduce your prescription drug expenses by asking your physician to prescribe generic drugs instead of brand name drugs, when available. Generic drugs are safe, effective medication that cost less than equivalent brand name drugs.

Best Value

If you and your doctor agree that a generic drug on the formulary is the best for you, you will pay your first-tier copay. Generics provide you with the best value and lowest out-of-pocket cost.

More Choice More Cost

If you receive a prescription for a brand name drug on the formulary you will pay your second-tier copay.

- Lower your cost: Talk to your physician to see if a generic medication is available for the prescribed band name drug.

Most Choice Most Expensive

Non-formulary drugs require you to pay the third-tier copay, your highest out-of-pocket cost.

- Lower your cost: Talk to your physician to see if a formulary brand name or generic medication is available.

Vision Benefits

You are able to access vision care discounts through Davis Visions Affinity Program. The program provides high quality professional services and ophthalmic materials such as frames, corrective eyeglasses and contact lenses at significant cost reductions. Simply show your ID card to a participating provider and they will apply the appropriate discount at the time of purchase.

Once a member receives an eye exam from a participating Davis Vision provider, Optometrist or Ophthalmologist (see our provider directory or use the *Find a Provider* feature on our web site www.bsneny.com), he or she is eligible for the discount program. A member must obtain services for their materials coverage through a Davis Provider. Most Davis providers will honor prescriptions from participating Optometrists or Ophthalmologists. A member is eligible for the discount program on an unlimited basis for the rest of the plan year.

	Member Cost
Routine Refractive Eye Exam	One exam every two years; Children under age 14 with refractive error can receive one exam every year
Frames	
Priced up to $70 retail	$40
Priced over $70 retail	$40 plus 10% off the amount over $70
Lenses *(Uncoated Plastic)*	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Lens Option *(add to above lens price)*	
Standard Progressive (no-line bifocals)	$75
Premium Progressive	$125
Glass Lenses	$18
Polycarbonate Lenses	$30
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Scratch Resistant Coating	$15
Standard Anti-Reflective Coating	$45
Ultraviolet Coating	$15
Solid Tint	$10
Gradient Tint	$12
Photogrey Tint	$35
Plastic Photosensitive	$65
High Index Lenses	$55
Polarized Lenses	$75
Contact Lenses ***Free membership in Lens 123® replacement contact lens by mail program.***	20% off retail prices
Disposable Contact Lenses	10% discount from retail prices *Contact lens fitting fee may not be covered*
Non-Prescription Sunglasses	20% discount from retail prices
Accessories and Contact Lens Solution	10% discount from retail prices
Laser Vision Correction	Up to 25% off retail *or receive an additional 5% discount on any advertised specials--whichever is lowest*

Discounts subject to change

Benefits may not duplicate those already provided through your group plan or those that may be provided by any vision rider added to your group plan.