Rensselaer-Columbia-Greene Health Insurance Trust

	Current PPO 812	*Preferred Plan 2 PPO 815*
DEDUCTIBLES/MAXIMUMS		
In network deductible	N/A	N/A
In network coinsurance	N/A	N/A
In network out of pocket maximum	$6,350/$12,700	$6,350/$12,700
Out of network deductible	$250/$500	$500/$1000
Out of network coinsurance	20%	30%
Out of network out of pocket maximum	$2,500/$5,000	$2,500/$5,000
Out of network annual maximum	Unlimited	Unlimited
Out of network lifetime maximum	Unlimited	Unlimited
Annual maximum	Unlimited	Unlimited
Benefit administration	Calendar year benefits	Calendar year benefits
Dependent age	26	26
Student age	26	26
Dependent/Student coverage ends	End of birth month	End of birth month
Domestic partner	No coverage for domestic partner	No coverage for domestic partner
PRESCRIPTION DRUG		
Prescription copay	N/A	N/A
Mail order copay per 90 day supply	N/A	N/A
Mandatory mail order applies	N/A	N/A
Prescription deductible	N/A	N/A
Generic oral contraceptive coverage	N/A	N/A
PHYSICIAN SERVICES – Office		
Primary care physician copay	$10	$25
Specialist copay	$10	$25
Pediatric visits for children up to age 19	Covered in full	Covered in full
Well child visits and immunizations for children up to age 19	Covered in full	Covered in full
Allergy immunotherapy	Covered in full	Covered in full
Chiropractic	$10	$25
Laboratory services	Covered in full	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full	Covered in full
Pre & post natal care	Covered in full after $10 copay	Covered in full after initial $25 copay
PHYSICIAN SERVICES - Routine/Preventive		
Abdominal aortic aneurysm screening	Covered in full	Covered in full
Adult immunizations	Covered in full	Covered in full
Flu shot	Covered in full	Covered in full
Bone mineral density	Covered in full	Covered in full
Colorectal cancer screening	Covered in full	Covered in full
Colonoscopy	Covered in full	Covered in full
Routine mammogram	Covered in full	Covered in full
OB/GYN	Covered in full	Covered in full
Routine pap smear	Covered in full	Covered in full
Physical exam	Covered in full	Covered in full
PSA test	Covered in full	Covered in full
Routine eye exam	Covered in full every other year	Covered in full every other year
HOSPITAL		
Inpatient hospital stay	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Inpatient maternity stay	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Inpatient physical rehab (60 days)	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Outpatient surgery	Covered in full	$200
EMERGENCY HOSPITAL CARE		
Emergency room (copay waived if admitted to hospital)	$35	$100
Ambulance - ground ambulance	Covered in full	Covered in full
Ambulance - air ambulance	Covered in full	Covered in full
Urgent care centers	$10	$25
MENTAL HEALTH & SUBSTANCE ABUSE		
Mental health (inpatient)	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Mental health (outpatient)	Covered in full	Covered in full
Alcohol & substance abuse (inpatient detox)	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Alcohol & substance abuse (inpatient rehab)	Covered in full	$250 per admission (limit 3 copays/mbr/year)
Alcohol & substance abuse (outpatient)	Covered in full	Covered in full
DIABETIC SUPPLIES & SERVICES		
Diabetic equipment & supplies (test strips, syringes, etc.)	$10	$25
OTHER SERVICES		
Cardiac rehabilitation (24 visits)	$10	$25
Chemotherapy	$10	$25
Dialysis	$10	$25
Durable medical equipment	Covered in full in network	Covered in full in network
Home care (100 visits)	$10	$25
Hospice (210 days)	$10	$25
Physical, speech & occupational therapy (60 visits aggregate)	$10	$25
Post-mastectomy prosthetics	Covered in full	Covered in full
Prosthetic and orthotic appliances	Covered in full in network	Covered in full in network
Radiation therapy	$10	$25
Skilled nursing facility (120 days)	Covered in full	$250 per admission (limit 3 copays/mbr/year)

THIS IS A BENEFIT SUMMARY...IN THE CASE OF A DISCREPANCY THE CONTRACT IS THE 'MASTER DOCUMENT'

Traditional Blue

BlueShield of Northeastern New York

Traditional Blue PPO 815

Prepared for: RCGHIT Preferred PPO

PPO 815

NO copay under PPO 812

Benefits where a copay is introduced under the Preferred PPO:

	In-Network
EKG, ECG, EEG	$25 co-pay
Allergy Testing (Office Visit)	$25 co-pay
Fetal Non-Stress Test	$25 co-pay
Infusion Therapy	$25 co-pay
Surgery (Physicians office)	$25 co-pay
Injectable Medication, non-self administered	$25 co-pay

2014-15 Rates
New Contract

PPO Plan Family	Employee Share	Family Premium Total	Employee share
812	16%	$ 21,074	$ 3,372
815	14%	$ 19,663	$ 2,750
		Employee savings	$ 622

PPO Plan 2 Person	Employee Share	2 Person Premium Total	Employee Share
812	16%	$ 19,928	$ 3,188
815	14%	$ 18,650	$ 2,600
		Employee savings	$ 588

PPO Plan Single	Employee Share	Single Premium Total	Employee Share
812	16%	$ 7,581	$ 1,213
815	14%	$ 7,090	$ 995
		Employee savings	$ 218