East Greenbush Central School

Traditional Blue POS 211

DEDUCTIBLES/MAXIMUMS	
In network deductible	None
In network coinsurance	None
In network out of pocket maximum	$4,500/$9,000
Out of network deductible	$100/$300
Out of network coinsurance	20%
Out of network out of pocket maximum	$2,500/$5,000
Out of network lifetime maximum	Unlimited
Benefit administration	Calendar year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of birth month
Domestic partner	Not covered
PRESCRIPTION DRUG	
Prescription copay	$5/$20/$35
Mail order copay per 90 day supply	2 copays
Mandatory mail order applies	N/A
Prescription deductible	N/A
Generic oral contraceptive coverage	Covered in full
PHYSICIAN SERVICES - Office	
Primary care physician copay	$10
Specialist copay	$10
Pediatric visits for children up to age 19	$10
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	Covered in full
Chiropractic	$10
Laboratory services	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full
Pre & post natal care (routine)	Covered in full after initial $10 copay
PHYSICIAN SERVICES - Routine/Preventive	
Abdominal aortic aneurysm screening	Covered in full
Adult immunizations	Covered in full
Flu shot	Covered in full
Bone mineral density	Covered in full
Colorectal cancer screening	Covered in full
Colonoscopy	Covered in full
Routine mammogram	Covered in full
OB/GYN	Covered in full
Routine pap smear	Covered in full
Physical exam	Covered in full
PSA test	Covered in full
Routine eye exam (every other year)	Covered in full
HOSPITAL	
Inpatient hospital stay	Covered in full
Inpatient maternity stay	Covered in full
Inpatient physical rehabilitation (60 days)	Covered in full
Outpatient surgery	$10
EMERGENCY HOSPITAL CARE	
Emergency room	Covered in full
Ambulance - ground ambulance	Covered in full
Ambulance - air ambulance	Covered in full
Urgent care centers	$10

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MENTAL HEALTH & SUBSTANCE ABUSE	
Mental health (inpatient)	Covered in full
Mental health (outpatient)	Covered in full
Alcohol & substance abuse (inpatient detox)	Covered in full
Alcohol & substance abuse (inpatient rehab)	Covered in full
Alcohol & substance abuse (outpatient)	Covered in full
DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$10
OTHER SERVICES	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	$10
Chemotherapy	$10
Dialysis	$10
Durable medical equipment (20% coinsurance out-of-network)	Covered in full
Home care (100 visits)	Covered in full
Hospice (Unlimited days)	Covered in full
Speech & occupational therapy (30 aggregate visits)	$10
Physical therapy (30 visits)	$10
Post-mastectomy prosthetics	Covered in full
Prosthetic and orthotic appliances	Not covered
Radiation therapy	$10
Skilled nursing facility (100 days)	Covered in full

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