East Greenbush Central School

PPO 815

DEDUCTIBLES/MAXIMUMS	
In network deductible	n/a
In network coinsurance	n/a
In network out of pocket maximum	$4,500/$9,000 (Emb)
Out of network deductible	$500/$1,000 (Emb)
Out of network coinsurance	30%
Out of network out of pocket maximum	$2,500/$5,000 (Emb)
Out of network annual maximun	Unlimited
Out of network lifetime maximun	Unlimited
Annual maximum	Unlimited
Benefit administration	Calendar Year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of the birth month
Domestic partner	Not covered
PRESCRIPTION DRUG	
Prescription copay	$10/$30/$50
Mail order copay per 90 day supply	2 copays
Mandatory mail order applies	N/A
Prescription deductible	N/A
PHYSICIAN SERVICES - Office	
Primary care physician copay	$25
Specialist copay	$25
Pediatric visits for children up to age 19	$25
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	Covered in full
Chiropractic	$25
Laboratory services	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full
Pre & post natal care	Covered in full after initial primary care physician 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 (covered in full every other year)	Covered in full
HOSPITAL	
Inpatient hospital stay	$250
Inpatient maternity stay	$250
Inpatient physical rehab	60 days, $250
Outpatient surgery	$200
EMERGENCY HOSPITAL CARE	
Emergency room (copay waived if admitted to hospital)	$100
Ambulance - ground ambulance	Covered in full
Ambulance - air ambulance	Covered in full
Urgent care centers	$25

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BlueShield of Northeastern New York

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MENTAL HEALTH & SUBSTANCE ABUSE	
Mental health (inpatient)	$250
Mental health (outpatient)	Covered in full
Alcohol & substance abuse (inpatient detox)	$250
Alcohol & substance abuse (inpatient rehab)	$250
Alcohol & substance abuse (outpatient)	Covered in full
DIABETIC SUPPLIES & SERVICES	
Diabetic equipment & supplies (test strips, syringes, etc.)	$25
OTHER SERVICES	
Cardiac rehabilitation (24 visits)	24 visits, $25
Chemotherapy	$25
Dialysis	$25
Durable medical equipment	Covered in full in network
Home care	100 visits, $25
Hospice	210 days, $250
Physical, speech & occupational therapy	60 visits aggregate, $25
Post-mastectomy prosthetics	Covered in full
Prosthetic and orthotic appliances	Covered in full
Radiation therapy	$25
Skilled nursing facility	120 days, $250

**For a list of creditable prescription drug plans, please refer to our website, bsneny.com*
***This is a summary of covered benefits and exclusions and is*
detail all benefits, limitations and exclusions that may apply.