HIGHMARK. NORTHEASTERN NEW YORK **1-844-639-2440** **Highmark.com/blueshieldneny**

Benefit Summary for Group:

CASHIC-East Greenbush CSD

Effective Date: 7/1/2022

	PPO 800		
	In-Network	**Out-of-Network**	**Additional Information**
General Information			
Provider Network	PPO Network		
Deductible	N/A	$250 single / $500 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	20% coinsurance after deductible	
Out of Pocket Maximum	$6,850 single / $13,700 family	$2,500 single / $5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Not covered		
Prescription Drug Coverage			
Prescription Drugs	$10/$30/$50	Not Covered	
Mail Order	$20/$60/$100 per 90 day supply	Not Covered	

	PPO 800		
	In-Network	Out-of-Network	Additional Information
Physician and Other Services			
Primary Office Visit	$25 copayment	20% coinsurance after deductible	
Specialist Office Visit	$25 copayment	20% coinsurance after deductible	
Telemedicine	$10 copayment	Not covered	
Allergy Injections	Covered in full	20% coinsurance after deductible	
Allergy Testing	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	$25 copayment/$25 copayment	20% coinsurance after deductible	
PCP Copay/Coinsurance for Dependents up to age 19	$25 copayment	20% coinsurance after deductible	
Specialist Copay/Coinsurance for Dependents up to age 19	$25 copayment	20% coinsurance after deductible	
Emergency and Urgent Care Services			
Emergency Room	$150 copayment	Covered as in-network	Prudent layperson language applies. Emergency Room cost-share waived if admitted; inpatient benefits now apply.
Ambulance	$150 copayment	Covered as in-network	
Urgent Care Center	$35 copayment	Covered as in-network	
Preventive Services			
Bone mineral density measurement or test	Covered in full	20% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full	20% coinsurance after deductible	
Immunizations	Covered in full	20% coinsurance after deductible	
Mammogram	Covered in full	20% coinsurance after deductible	
Pap Smear	Covered in full	20% coinsurance after deductible	
Routine Physical Exam	Covered in full	Not covered	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full	20% coinsurance after deductible	
Well Child Visits	Covered in full	20% coinsurance after deductible	
Hospital Services			
Inpatient Hospital	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	

	PPO 800		
	In-Network	Out-of-Network	Additional Information
Hospital Services			
Outpatient Surgical Procedure (Facility)	$100 copayment	20% coinsurance after deductible	Prior auth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	Unlimited Days
Diagnostic Testing Services			
Laboratory Tests	$25 copayment	20% coinsurance after deductible	
Radiology	$25 copayment	20% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$25 copayment/$25 copayment	20% coinsurance after deductible	
Inpatient Maternity	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	One cost share applies to both maternity and newborn services. No separate cost share for newborns, but will apply to NICU.
Mental Health and Substance Abuse			
Inpatient Mental Health	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Outpatient Mental Health	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	$250 per admission, not to exceed $500 single/$750 family	20% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	20% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	$25 copayment	20% coinsurance after deductible	
Insulin and Other Oral Agents	$5 copayment	20% coinsurance after deductible	If administered by pharmacy vendor copay is lesser of Rx or office visit copay.
Diabetic Medical Supplies (Test strips, Syringes, etc)	$25 copayment	20% coinsurance after deductible	

	PPO 800		
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Rehabilitation Services			
Chiropractic Care	$25 copayment/$25 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$25 copayment/$25 copayment	20% coinsurance after deductible	60 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$25 copayment/$25 copayment	20% coinsurance after deductible	
Additional Services			
Chemotherapy - Outpatient Facility	Covered in full	20% coinsurance after deductible	
Durable Medical Equipment	Covered in full	20% coinsurance after deductible	
Home Health Care	$25 copayment/$25 copayment	20% coinsurance after deductible	100 Visits IN & OON
Hospice	Covered in full	20% coinsurance after deductible	
Prosthetics & orthotics	Covered in full	20% coinsurance after deductible	
Dialysis	Covered in full	20% coinsurance after deductible	
Wellness Card	Not covered	Not covered	
Pediatric Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	$25 copayment/$25 copayment	20% coinsurance after deductible	
Adult Vision Services			
Routine Exam	Covered in full	Not covered	1 every calendar year
Medical Eye Exam	$25 copayment/$25 copayment	20% coinsurance after deductible	

*Cost share may vary based on place of service for services listed above.

**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.