East Greenbush CSD PPO 800 10652013

On the chart below, you'll see what you pay for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	JULY 1, 2025	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Deductible Accumulation (2)	Not applicable	Embedded
Coinsurance - payment based on the plan allowance	Not applicable	20% after deductible
Out-of-Pocket Maximum (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,850 $13,700	 $2,500 $5,000
Out-of-Pocket Accumulation (2)	Embedded	Embedded
Office/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits	$25 copay	20% after deductible
Specialist Office Visits & Virtual Visits	$25 copay	20% after deductible
Virtual Visit Provider Originating Site Fee	$0 copay	20% after deductible
Urgent Care Center Visits	$35 copay	$35 copay
Telemedicine Services (3)	Covered in full	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 covered in full	 not covered
Adult Immunizations	covered in full	20% after deductible
Routine Gynecological Exams, including a Pap Test	covered in full	20% after deductible
Mammograms, Annual Routine	covered in full	20% after deductible
Mammograms, Medically Necessary	$25 copay	20% after deductible
Diagnostic Services and Procedures	covered in full	20% after deductible
Routine Pediatric Physical Exams	 covered in full	 20% after deductible
Pediatric Immunizations	covered in full	20% after deductible
Diagnostic Services and Procedures	covered in full	20% after deductible
Emergency Services		
Emergency Room Services (5)	$150 copay (waived if admitted); $35 copay for freestanding urgent care facility	
Ambulance - Emergency and Non-Emergency	$150 copay	$150 copay
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	$250 inpatient copay/admission; limit: $500 inpatient copay/member inpatient copayment limit/benefit period, $750 inpatient copay/family inpatient copayment limit/benefit period, aggregate with inpatient medical and inpatient substance abuse	20% after deductible
Outpatient Surgery	$100 copay	20% after deductible
Maternity (non-preventive professional services) including dependent daughter	$25 copay (copay on initial visit only)	20% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	$25 copay	20% after deductible

Benefit	In Network	Out of Network
	limit: 60 visits/benefit period aggregate with occupational therapy and speech therapy	
Respiratory Therapy	$25 copay	20% after deductible
Speech Therapy	$25 copay	20% after deductible
	limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine	
Occupational Therapy	$25 copay	20% after deductible
	limit: 60 visits/benefit period aggregate with speech therapy and physical medicine	
Spinal Manipulations	$25 copay	20% after deductible
Cardiac Rehabilitation Therapy	$25 copay	20% after deductible
Infusion Therapy	$25 copay	20% after deductible
Chemotherapy	covered in full	20% after deductible
Radiation Therapy	covered in full	20% after deductible
Dialysis	covered in full	20% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$250 inpatient copay/admission; limit: $500 inpatient copay/member inpatient copayment limit/benefit period, $750 inpatient copay/family inpatient copayment limit/benefit period, aggregate with inpatient medical and inpatient substance abuse	20% after deductible
Inpatient Detoxification / Rehabilitation	$250 inpatient copay/admission; limit: $500 inpatient copay/member inpatient copayment limit/benefit period, $750 inpatient copay/family inpatient copayment limit/benefit period, aggregate with inpatient medical and inpatient mental health	20% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	covered in full	20% after deductible
Outpatient Substance Abuse Services	covered in full	20% after deductible
Other Services		
Allergy Extracts and Injections	covered in full	20% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder	covered in full	20% after deductible
Assisted Fertilization Procedures (GIFT & ZIFT excluded)	See Service Category (i.e. lab, surgery, radiology)	See Service Category (i.e. lab, surgery, radiology)
	Benefit Limit: 3 Cycles per Lifetime for In Vitro Fertilization	
Dental Services Related to Accidental Injury	See Service Category (i.e. lab, surgery, radiology)	See Service Category (i.e. lab, surgery, radiology)
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$25 copay	20% after deductible
Standard Imaging	$25 copay	20% after deductible
Diagnostic Medical	$25 copay	20% after deductible
Pathology/Laboratory	$25 copay	20% after deductible
Allergy Testing	covered in full	20% after deductible
Durable Medical Equipment and Supplies	DME covered in full; $25 copay for diabetic supplies; $25 copay for diabetic equipment	20% after deductible
Orthotics	covered in full	20% after deductible
Prosthetic Devices	covered in full	20% after deductible
Home Health Care	$25 copay	20% after deductible
	limit: 100 visits/benefit period aggregate with visiting nurse and home infusion therapy	
Hospice	covered in full	20% after deductible
Infertility Counseling, Testing and Treatment	See Service Category (i.e. lab, surgery, radiology)	See Service Category (i.e. lab, surgery, radiology)
Skilled Nursing Facility Care	$250 inpatient copay/admission; limit: $500 inpatient copay/member inpatient copayment limit/benefit period, $750 inpatient copay/family inpatient copayment limit/benefit period, aggregate with inpatient medical and inpatient substance abuse	20% after deductible

Benefit	In Network	Out of Network
Transplant Services	$250 inpatient copay/admission; limit: $500 inpatient copay/member inpatient copayment limit/benefit period, $750 inpatient copay/family inpatient copayment limit/benefit period, aggregate with inpatient medical and inpatient substance abuse	20% after deductible
Prescription Drugs		
Prescription Drug Deductible Individual Family	 none none	
Prescription Drug Program (6) Defined by the National Plus NY Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30/60/90-day Supply)** $10 / $10 / $10 Formulary generic copay $30 / $30 / $30 Formulary brand copay $50 / $50 / $50 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply **Specialty Drugs** $10 Formulary generic copay $30 Formulary brand copay $50 Non-Formulary brand copay **Maintenance Drugs through Mail Order (30/60/90-day Supply)** $20 / $20 / $20 Formulary generic copay $60 / $60 / $60 Formulary brand copay $100 / $100 / $100 Non-Formulary brand copay Cost-sharing for prescription insulin drugs will not exceed $100 for a 30-day supply	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above.

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é bíká'ígíí bich´j´dahodootnih.

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