Excellus

Type of Care/Plan Benefits	Coverage
Plan features	
Primary Care Physician (PCP)	No copay, office visit covered subject to deductible and coinsurance
Referrals	Not required
Out of network benefits	Covered
Out of area benefits	Coverage provided worldwide through the BlueCard program.
Student/Dependent coverage	Qualified dependents and students are covered to age 26.
Domestic partner	Not covered
Plan cost-sharing highlights	
Office visit copay (Primary Care Physician)	No copay, office visit covered subject to deductible and coinsurance
Office visit copay (Specialist)	No copay, office visit covered subject to deductible and coinsurance
Coinsurance	20%, enhanced benefits only, unless noted
Deductible	$50 individual / $150 family, enhanced benefits only
Annual coinsurance maximum	$400 individual / $1200 family, enhanced benefits only
Annual pharmacy maximum	$2000 individual / $6000 family

type of care/plan benefits	Coverage
Wellness Incentive	
Stay healthy with great programs and incentives!	Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.
Preventive Health Care Services	
Well child visits	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year
Adult immunizations	Covered in full
Mammography	Covered in full
Pap smear	Covered in full
Routine GYN exam	Covered in full
Prostate cancer screening	Covered in full
Routine vision	Not covered
Colonoscopy	Covered in full
Physician Office Services	
Diagnostic office visits	Subject to deductible and coinsurance
Diagnostic x-rays	Covered in full
Diagnostic laboratory and pathology	Covered in full
Allergy tests	Subject to deductible and coinsurance
Allergy injections	Subject to the deductible and coinsurance
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Maternity Services	
Prenatal and postpartum care	Covered in full
Hospital care for mom (including delivery)	Covered in full
Newborn nursery care	Covered in full
Prescription Drug	

continued

Excellus

Type of Care/Plan Benefits	Coverage
• **Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through PrimeMail mail order pharmacy. Contraceptives included.**	• $5/$20/$40
Inpatient Hospital Benefits	
• **Hospital benefits**	• Covered in full for unlimited days
• **Physician visits in the hospital**	• Covered in full
• **Inpatient physical rehabilitation**	• Covered in full for 30 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days
• **Surgery**	• Covered in full
• **Anesthesia**	• Covered in full
Emergency Care	
• **Emergency room care**	• Covered in full
• **Freestanding urgent care center**	• Covered in full
• **Ambulance**	• Covered in full
Outpatient Hospital Benefits	
• **Diagnostic x-rays**	• Covered in full
• **Diagnostic laboratory and pathology**	• Covered in full
• **Surgical care**	• Covered in full
• **Chemotherapy**	• Covered in full
• **Radiation therapy**	• Covered in full
Mental Health and Chemical Dependence	
• **Inpatient mental health care**	• Covered in full for unlimited days
• **Outpatient mental health care**	• Covered in full for unlimited visits
• **Inpatient chemical dependence**	• Covered in full for unlimited days
• **Outpatient chemical dependence**	• Covered in full for unlimited visits
Other Services	
• **Diabetic insulin and supplies**	• Covered in Full
• **Skilled nursing facility**	• Covered in full for 100 days. After basic benefits exhausted, not subject to deductible and coinsurance for unlimited days
• **Home care**	• Covered in full for up to 60 visits per year. Subject to deductible and coinsurance after basic benefits have exhausted for up to 325 visits per year
• **Hospice**	• Covered in full for unlimited days
• **Outpatient therapy**	• Subject to deductible and coinsurance, limited to 100 visits per calendar year
• **Durable medical equipment**	• Subject to deductible and coinsurance
• **External prosthetics**	• Subject to deductible and coinsurance
• **Chiropractic**	• Subject to deductible and coinsurance
• **Acupuncture**	• Not covered
• **Dental**	• Not covered
• **Hearing**	• Not covered

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. These benefits should not be interpreted as pre-approval of services. Certain services may be subject to additional requirements described in the member's insurance policy. Payment of claims related to these benefits are subject to the member's eligibility on the date of service and the resolution of any other outstanding claims. The member is responsible for payment of a copay, deductible, coinsurance or any combination based on plan design. Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act may not be quoted herein. Please refer to the Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Protection and Affordable Care Act requirements. Benefits herein are subject to change as a result of efforts to implement federal health care reform and mental health and substance abuse care parity initiative. There may be additional coverage for biologically-based mental illness and for children with serious emotional disturbances as defined by Timothy's Law.