Classic Blue $50/$150 with 10-25-40 RX

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

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 Express Scripts mail order pharmacy. Contraceptives included.**	• $10/$25/$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