Classic Blue Benefits $50/$150 with $5/$15/$30 RX (YO)
Groton Central School District

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
· Out of pocket maximum - Medical	· $400 individual / $1200 family, enhanced benefits only
· Lifetime maximum	· None
. Prescription Drug - out-of pocket copayment maximum	· $1,000 Individual / $3,000

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 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

continued

Type of Care/Plan Benefits	Coverage
Prescription Drug	
· **Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply is available through Express Scripts and Wegmans Home Delivery pharmacy. Contraceptives included.**	· $5/$15/$30
Inpatient Hospital Benefits	
· **Hospital benefits**	· Covered in full
· **Physician visits in the hospital**	· Covered in full
· **Inpatient physical rehabilitation**	· Covered in full, limited to 30 days per year. Subject to no deductible and coinsurance after basic benefits have exhausted 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
· **Outpatient mental health care**	· Covered in full
· **Inpatient chemical dependence**	· Covered in full
· **Outpatient chemical dependence**	· Covered in full
Other Services	
· **Diabetic insulin and supplies**	· 20% , enhanced benefit
· **Skilled nursing facility**	· Covered in full, limited to 100 days per year. Subject to no deductible and coinsurance after basic benefits have exhausted for unlimited days
· **Home care** and	· Covered in full for up to 60 visits per year. Subject to deductible coinsurance after basic benefits have exhausted for up to 325 visits per year
· **Hospice**	· Covered in full
· **Outpatient therapy**	· Subject to deductible and coinsurance
· **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

Please Note: This is an outline of benefits only. Official benefits and conditions of coverage are outlined in your member certificate. Benefit questions should be directed to Customer Service at 1-800-499-1275.

Professional Non-participating Provider In-area covered at 100% of current Medicare National rates; Out-of-area covered at 150% of current Medicare National rates. Facility Non-participating covered at 80% of charge. The following services require preauthorization: organ transplants, non-mandated reproductive procedures (IVF, GIFT & ZIFT).