Excellus BluePPO Benefits
Town of Caroline PPO Plan

Excellus

Type of Care/Plan Benefits	In-Network	Out Of Network
Plan features		
. Primary Care Physician (PCP)	• Not required	
. 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	• Covered	
. Coverage Period	• January 1st - December 31st	
Plan cost-sharing highlights		
. Office visit copay (Primary Care Physician)	• $10 copay	
. Office visit copay (Specialist)	• $10 copay	
. Coinsurance	• In-network: None; Out-of-network: 20%	
. Deductible	• In-network: None Out of Network $250 individual /$750 family	
. Out of pocket maximum	• In-network: None; Out of Network $1,000 individual /$3,000 family	
. Lifetime maximum	• None	

type of care/plan benefits	In-Network	Out Of Network
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.	• 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	• Covered in full
. Adult routine physical exams	• Covered in full for 1 exam per year according to national guidelines	• Covered at 80%, subject to the deductible for one routine exam per year
. Adult immunizations	• Covered in full	• Not Covered
. Mammography	• Covered in full	• Covered at 80%, subject to the deductible
. Pap smear	• Covered in full	• Covered at 80%, subject to the deductible
. Routine GYN exam	• Covered in full	• Covered at 80%, subject to the deductible
. Prostate cancer screening	• $10 copay	• Covered at 80%, subject to the deductible
. Routine vision	• $10 copay for one routine exam every year; $60 eyewear allowance available per year	• Covered at 80%, subject to the deductible for one routine exam per year. $60 eyewear allowance available per year
. Colonoscopy	• Preventive and diagnostic covered according to the surgical benefit	• Covered at 80%, subject to the deductible
. New York State women's preventative services mandate	• Covered effective 1/1/13	

continued

Type of Care/Plan Benefits	In-Network	Out Of Network
Physician Office Services		
. Diagnostic office visits	• $10 copay per visit	• Covered at 80%, subject to the deductible
. Diagnostic x-rays	• $10 copay. Precertification applies for MRI, PET and CAT scans.	• Covered at 80%, subject to the deductible. Precertification applies to MRI, PET and CAT scans.
. Diagnostic laboratory and pathology	• Covered in full	• Covered at 80%, subject to the deductible
. Allergy tests	• $10 copay per visit	• Covered at 80%, subject to the deductible
. Allergy injections	• Covered in full	• Covered at 80%, subject to the deductible
. Chemotherapy	• Covered in full	• Covered at 80%, subject to the deductible
. Radiation therapy	• Covered in full	• Covered at 80%, subject to the deductible
Maternity Services		
. Prenatal Care	• Covered in full	• Covered at 80%, subject to the deductible
. Hospital care for mom (including delivery)	• Hospital-Covered in full; Delivery-Covered in full	• Covered at 80%, subject to the deductible
. Newborn nursery care	• Covered in full	• Covered at 80%, subject to the deductible
Prescription Drug		
. Short-term and maintenance drugs	• Not covered	• Not covered
Inpatient Hospital Benefits		
. Hospital benefits	• Covered in full for unlimited days. Precertification applies.	• Covered at 80%, subject to the deductible. Precertification applies.
. Physician visits in the hospital	• Covered in full	• Covered at 80%, subject to the deductible
. Inpatient physical rehabilitation	• Covered in full for up to 60 days per year. Precertification applies.	• Covered at 80%, subject to the deductible for up to 60 days per year. Precertification applies.
. Surgery	• Covered in full	• Covered at 80%, subject to the deductible
. Anesthesia	• Covered in full	• Covered at 80%, subject to the deductible
Emergency Care		
. Emergency room care	• $100 copay per visit, unless admitted within 24 hours	• $100 copay per visit, unless admitted within 24 hours
. Freestanding urgent care center	• $25 copay per visit	• Covered at 80%, subject to the deductible
. Ambulance	• Covered in full	• Covered in full
Outpatient Hospital Benefits		
. Diagnostic x-rays	• $10 copay per visit. Precertification applies for MRI, PET and CAT scans.	• Covered at 80%, subject to the deductible. Precertification applies to MRI, PET and CAT scans
. Diagnostic laboratory and pathology	• Covered in full	• Covered at 80%, subject to the deductible

continued

Type of Care/Plan Benefits	In-Network	Out Of Network
• **Surgical care**	• Covered in full	• Covered at 80%, subject to the deductible
• **Chemotherapy**	• Covered in full	• Covered at 80%, subject to the deductible
• **Radiation therapy**	• Covered in full	• Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence		
• **Inpatient mental health care**	• Covered in full for unlimited days. Precertification applies.	• Covered at 80%, subject to the deductible. Precertification applies.
• **Outpatient mental health care**	• $10 copay. Services can be provided in an outpatient facility or in a provider office.	• Covered at 80%, subject to the deductible. Services can be provided in an outpatient facility or in a provider office.
• **Inpatient chemical dependence**	• Covered in full for unlimited days. Precertification applies.	• Covered at 80%, subject to the deductible. Precertification applies.
• **Outpatient chemical dependence**	• $10 copay per visit	• Covered at 80%, subject to the deductible
Other Services		
• **Diabetic insulin and supplies**	• $10 copay for up to a 30 day supply	• Covered at 80%, subject to the deductible for up to a 30 day supply
• **Skilled nursing facility**	• Covered in full for up to 120 days per year. Precertification applies.	• Covered at 80%, subject to the deductible for up to 120 days per year. Precertification applies.
• **Home care**	• Covered in full for unlimited visits. Precertification applies.	• Covered at 80%, subject to a $50 deductible for unlimited visits per year. Precertification applies.
• **Hospice**	• Covered in full for unlimited days	• Covered at 80%, subject to the deductible for unlimited visits per year
• **Outpatient therapy**	• $10 copay per visit for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy	• Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy
• **Durable medical equipment**	• Covered at 80%. Precertification applies.	• Covered at 80%, subject to the deductible. Precertification applies.
• **External prosthetics**	• Covered at 80%	• Covered at 80%, subject to the deductible
• **Chiropractic**	• $10 copay per visit	• Covered at 80%, subject to the deductible
• **Acupuncture**	• Covered at 50% for up to 10 visits per year	• Covered at 50%, subject to the deductible, for up to 10 visits per year
• **Dental**	• $10 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
• **Hearing**	• Routine exams not covered	• Routine exams not covered
• **New York State autism spectrum disorder mandate**	• Covered effective 1/1/13	