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	

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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

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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	

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.