Classic Blue Benefits $100/$300 with $5/$10/$25 RX (YD)
TST BOCES

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	· $100 individual / $300 family, enhanced benefits only
· Out of pocket maximum - Medical	· $400 individual / $1,200 family, enhanced benefits only
· Lifetime maximum	· None
. Prescription Drug - out-of pocket copayment maximum	· $1,000 Individual / $3,000 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 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

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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/$10/$25
Inpatient Hospital Benefits	
· Hospital benefits	· Covered in full
· Physician visits in the hospital	· Covered in full
· Inpatient physical rehabilitation deductible	· Covered in full, limited to 30 days per year. Subject to no 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% coinsurance , 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).