Classic Blue Traditional Benefits

Cayuga County Consortium

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	• $150 individual / $450 family, enhanced benefits only
. Out of pocket maximum	• $550 individual / $1650 family, enhanced benefits only
. Lifetime maximum	• None

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 Care	• Covered in full
. Hospital care for mom (including delivery)	• Covered in full
. Newborn nursery care	• Covered in full
Prescription Drug	
. Short-term and maintenance drugs	• $10/$25/$40

continued

Type of Care/Plan Benefits	Coverage
Inpatient Hospital Benefits	
. Hospital benefits	• Covered in full, Subject to deductible and coinsurance after basic benefits have exhausted; day limits may apply
. Physician visits in the hospital	• Covered in full; day limits may apply
. Inpatient physical rehabilitation	• Cost sharing is equal to Inpatient Hospital Services, 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, Subject to deductible and coinsurance after basic benefits have exhausted; day limits may apply
. Outpatient mental health care	• Covered in full
. Inpatient chemical dependence	• Covered in full, Subject to deductible and coinsurance after basic benefits have exhausted; day limits may apply
. Outpatient chemical dependence	• Covered in full for unlimited visits
Other Services	
. Diabetic insulin and supplies	• Covered in full
. Skilled nursing facility	• Covered in full, Subject to no deductible and coinsurance after basic benefits have exhausted for 100 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, 100 visits
. Durable medical equipment	• Subject to deductible and 20% coinsurance
. External prosthetics	• Subject to deductible and 20% coinsurance
. Chiropractic	• Subject to deductible and coinsurance
. Acupuncture	• Not covered
. Dental	• Not Covered
. Hearing	• Not covered