Classic Blue Traditional benefits

Prepared for Cayuga County

January, 2024

(DNO)

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	$250 individual / $750 family, enhanced benefits only
Out of pocket maximum	$400 individual / $1200 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

Type of Care/Plan Benefits	Coverage
Inpatient Hospital Benefits	
• **Hospital benefits**	• Covered in full
• **Physician visits in the hospital**	• Covered in full; day limits may apply
• **Inpatient physical rehabilitation**	• Covered in full. Limited to 30 days per year
• **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 -Day limits may apply
• **Outpatient mental health care**	• Covered in full
• **Inpatient chemical dependence**	• Covered in full- Day limits may apply
	• Covered in full for unlimited visits
• **Outpatient chemical dependence**	• Covered in full
Other Services	
• **Diabetic insulin and supplies**	• Covered in full
•	
• **Skilled nursing facility**	• Covered in full
• **Home care**	• Covered in full
• **Hospice**	• Covered in full
• **Outpatient therapy**	• Subject to deductible and 20% coinsurance
• **Durable medical equipment**	• Subject to deductible and 20% coinsurance
• **External prosthetics**	• Subject to deductible and 20% coinsurance
• **Chiropractic**	• Subject to deductible and 20% coinsurance
• **Acupuncture**	• Not Covered
• **Dental**	• Not covered
• **Hearing**	Not Covered