Classic Blue benefits - $100/$300 Deductible with $10/$20/$35 Rx (BSI)
TST BOCES Health Insurance Cooperative – Newfield Central School District

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 BlueCross BlueShield Global Core
· **Student/Dependent Coverage**	· Qualified dependents and students are covered to age 26
· **Domestic Partner**	· 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%
· **Deductible**	· $100 individual / $300 family, enhanced benefits only
· **Coinsurance Out of Pocket Maximum**	· $400 Individual / $1,200 Family
· **Prescription Drug Out of Pocket Maximum**	· $2,000 Individual / $6,000 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 Services	
· **Well Child Visits and Immunizations**	· Covered in full
· **Routine Physical Examinations**	· Covered in full, 1 exam per calendar year
· **Adult Immunizations**	· Covered in full
· **Routine Mammogram**	· Covered in full
· **Prostate Cancer Screening**	· Covered in full
· **Routine GYN & Cervical Screening**	· Covered in full
· **Bone Density Testing**	· Covered in full
· **Colonoscopy**	· Covered in full
Physician Office Services	
· **Diagnostic Office Visits & Diagnostic GYN Visits**	· Subject to deductible and coinsurance
· **Diagnostic Imaging, X-Rays, CAT, MRI**	· Covered in full
· **Diagnostic Laboratory and Pathology**	· Covered in full
· **Allergy Tests and Treatment**	· Subject to deductible and coinsurance
· **Allergy Injections**	· Subject to the deductible and coinsurance
· **Chemotherapy**	· Covered in full
· **Radiation Therapy**	· Covered in full
· **Chiropractic Care**	· Subject to the deductible and coinsurance
Maternity Services	
· **Prenatal Care**	· Covered in full
· **Maternity Care**	· Covered in full
· **Newborn Care**	· Covered in full
Prescription Drug	
	· $10/$20/$35; 30-day supply
	· $20/$40/$70; 90-day supply

Excellus

Type of Care/Plan Benefits	Coverage
Hospital Inpatient Services	
• Hospital Benefits	• Covered in full, unlimited days
• Physician Visits in the Hospital	• Covered in full
• Inpatient Physical Rehabilitation	• Covered in full, 30 days. (After basic benefit is exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible)
• Surgery	• Covered in full
• Anesthesia	• Covered in full
Emergency Services	
• Facility Emergency Room	• Covered in full
• Freestanding Urgent Care Center	• Covered in full
• Prehospital Emergency Services/Transportation	• Covered in full
Hospital Outpatient Services	
• Pre-admission/Pre-operative Testing	• Covered in full
• Diagnostic Imaging, X-Ray, CAT, MRI	• Covered in full
• Diagnostic Laboratory and Pathology	• Covered in full
• Surgical Care including Surgicenters & Freestanding Facilities	• Covered in full
• Chemotherapy	• Covered in full
• Radiation therapy	• Covered in full
• Dialysis	• Covered in full
Mental Health Care and Substance Use	
• Inpatient Mental Health Care	• Covered in full, unlimited days
• Outpatient Mental Health Care	• Covered in full
• Inpatient Substance Use, Detox, Rehab & Residential Care	• Covered in full, unlimited days
• Outpatient Substance Use Treatment	• Covered in full
Other Services	
• Treatment of Diabetes, Insulin & Supplies	• $10 copayment
• Skilled Nursing Facility	• Covered in full
• Home Care	• Covered in full, 60 visits per calendar year. (After basic benefit is exhausted, additional coverage subject to $50 deductible and 20% coinsurance up to 325 visits)
• Hospice	• Covered in full, (includes 5 bereavement counseling visits)
• Covered Therapies (Physical, Speech and Occupational)	• Subject to deductible and coinsurance, unlimited
• Cardiac Rehabilitation & Pulmonary Rehabilitation Therapy	• Covered in full, 1 program per lifetime
• Durable Medical Equipment (DME)	• Subject to deductible and coinsurance
• External Prosthetics/Orthotics	• Subject to deductible and coinsurance
• Medical Supplies	• Subject to deductible and coinsurance
• Diagnostic Hearing Exam	• Subject to deductible and coinsurance, routine not covered
• Diagnostic Eye Exam	• Subject to deductible and coinsurance, routine not covered
• Acupuncture	• Not covered