

H E A L T H P L A N C O M P A R I S O N



Excellus BlueCross BlueShield Blue Healthy Choices of CNY and Utica

	Fit & Healthy Lifestyle Benefits - \$300 annual allowance per family toward gym membership, Lasik, teeth whitening, toddler gym and swim programs and drivers education	Healthy Family Lifestyle Benefits - \$100 annual allowance per family toward gym membership, Lasik, teeth whitening, toddler gym and swim programs and drivers education
Plan Features		
Primary Care Physician (PCP)	Not Required	Not Required
Referrals	Not Required	Not Required
Out of network benefits	None	None
Out of area benefits	Coverage provided worldwide through the BlueCard® program	Coverage provided worldwide through the BlueCard® program
Student/Dependent coverage	Qualified dependents to age 19 & qualified students covered at age 23.	Qualified dependents to age 19 & qualified students covered at age 23.
Plan Cost Sharing Highlights		
Office visit copay (PCP)	\$20	Adults - \$25 • Kids to 19 - \$10
Office visit copay (Specialist)	\$40	\$40
Coinsurance	None	None
Deductible	None	None
Out of pocket maximum	None	None
Lifetime maximum	None	None
Plan Benefits		
Preventative Healthcare Services		
Well child visits	Covered in full	Covered in full
Adult routine physical exams	\$20 copay	\$25 copay
Adult immunizations	\$20 copay	\$25 copay
Mammography	Covered in full	Covered in full
Pap smear	Covered in full	Covered in full
Routine GYN Exam	Covered in full	Covered in full
Prostate cancer screening	\$20 copay	\$25 copay
Routine vision	\$20 copay for 1 routine eye exam every year; \$20 copay for children to age 19.	\$25 copay for 1 routine eye exam every year; \$0 copay for children to age 19. \$100 eyewear allowance for children to age 19.
Physicians Office Services		
Diagnostic office visits	PCP: \$20 copay • Specialist: \$40 copay	PCP: Adults \$20 copay, kids to 19 \$0 copay Specialist: \$40 copay
Diagnostic x-rays	\$40 copay	\$40 copay
Diagnostic lab. & pathology	Covered in full	Covered in full
Allergy Tests	PCP: \$20 copay • Specialist: \$40 copay	PCP: Adults \$25 copay, kids to 19 \$0 copay Specialist: \$40 copay
Allergy injections	PCP: \$20 copay • Specialist: \$40 copay	PCP: Adults \$25 copay, kids to 19 \$0 copay Specialist: \$40 copay
Chemotherapy	IV/injectable chemotherapy will be covered with a \$20 copay on the drug, in addition to a \$20 office visit copay.	IV/injectable chemotherapy will be covered with a \$25 copay on the drug, in addition to a \$25 office visit copay.
Radiation Therapy	\$20 copay	\$25 copay
Maternity Services		
Prenatal and postpartum care	\$20 copay for the first 10 visits, remainder covered in full	Covered in full
Hospital care for mom (including delivery)	Facility: Covered in full after a \$500 copay • Delivery: 20% coinsurance or \$200 copay, whichever is less	Facility: Covered in full • Physician: Covered in full
Newborn nursery care	Covered in full	Covered in full
Prescription Drug		
Short-term and maintenance drugs are covered under the following copayments for ea. 30-day supply per prescription at participating retail pharmacies, up to a 90-day supply (with 2 sep. copays for ea. 90-day supply) available through Express Scripts, Inc., mail order service. Contraceptives incl.	\$10/\$30/\$50 w/ \$0 generic for kids to age 19 IV/injectable drugs will be covered with a PCP/Specialist copay on the drug, in addition to PCP/Specialist copay for the visit.	\$10/\$30/\$50 w/ \$0 generic for kids to age 19 IV/injectable drugs will be covered with a PCP/Specialist copay on the drug, in addition to PCP/Specialist copay for the visit.
Inpatient Hospital Benefits		
Hospital benefits	Covered in full after a \$500 copay	Covered in full after a \$500 copay
Physician visits in the hospital	Covered in full	Covered in full
Inpatient Physical Rehabilitation	Covered in full after a \$500 copay for up to 60 days	Covered in full after a \$500 copay for up to 60 days
Surgery	20% coinsurance or a \$200 copay, whichever is less	Covered in full after a \$500 copay for up to 60 days
Anesthesia	Covered in full	Covered in full
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	\$40 copay	\$40 copay
Ambulance (ground)	\$100 copay for emergency transportation	\$100 copay for emergency transportation
Outpatient Hospital Benefits		
Diagnostic x-rays	\$40 copay	\$40 copay
Diagnostic lab. & pathology	Covered in full	Covered in full
Surgical Care	Facility: \$75 copay • Physician: \$40 copay IV/injectable chemotherapy will be covered with a \$20 copay on the drug, in addition to a \$20 visit copay.	Facility: \$75 copay • Physician: \$40 copay IV/injectable chemotherapy will be covered with a \$25 copay on the drug, in addition to a \$25 visit copay.
Chemotherapy	IV/injectable chemotherapy will be covered with a \$20 copay on the drug, in addition to a \$20 visit copay.	IV/injectable chemotherapy will be covered with a \$25 copay on the drug, in addition to a \$25 visit copay.
Radiation Therapy	\$20 copay	\$25 copay
Mental Health and Chemical Dependence Benefits		
Inpatient mental health care	covered in full after a \$500 copay for up to 30 days per calendar year	covered in full after a \$500 copay for up to 30 days per calendar year
Outpatient mental health care	\$40 copay for up to 20 visits per calendar yr. Services can be provided in an outpatient facility or in a provider's office.	\$40 copay for up to 20 visits per calendar yr. Services can be provided in an outpatient facility or in a provider's office.
Inpatient chemical dependence care	Covered in full after a \$500 copay for up to 7 days per calendar yr. for detoxification only.	Covered in full after a \$500 copay for up to 7 days per calendar yr. for detoxification only.
Outpatient Chemical Dependence Care	\$20 copay for up to 60 visits per calendar year	\$25 copay for up to 60 visits per calendar year
Other Services		
Diabetic insulin & supplies	\$20 copay for a 30-day supply Covered in full after a \$500 copay for up to 45 days per calendar yr.	\$25 copay for a 30-day supply Covered in full after a \$500 copay for up to 45 days per calendar yr.
Skilled nursing facility	360 day lifetime maximum.	360 day lifetime maximum.
Home care	Covered in full for up to 40 visits per calendar year	Covered in full for up to 40 visits per calendar year
Hospice	Covered in full after a \$500 copay for up to 210 days	Covered in full after a (\$250,\$500) copay for up to 210 days
Outpatient therapy	\$40 copay for up to 30 days combined visits for physical, speech, and occupational therapy.	\$40 copay for up to 30 days combined visits for physical, speech, and occupational therapy.
Durable medical equipment	Covered at 50% up to a \$5,000 max. per calendar year	Covered at 50% up to a \$5,000 max. per calendar year
External prosthetics	Covered at 50% up to a \$15,000 max. per calendar year	Covered at 50% up to a \$15,000 max. per calendar year
Chiropractic	\$40 copay	\$40 copay
Acupuncture	Not Covered	Not Covered
Dental	\$40 copay for accidental injury to sound and natural teeth and care due to congenital disease or anomaly	\$40 copay for accidental injury to sound and natural teeth and care due to congenital disease or anomaly
Hearing	\$20 PCP copay or \$40 specialist copay for diagnostic hearing exams. Hearing aids not covered.	\$25 PCP or \$40 specialist copay for adults and \$0 PCP copay or \$40 Specialist copay for children to age 19 for diagnostic hearing exams \$600 hearing aid allowance once every 3 years for children to age 19

This Summary is intended to serve only as a quick reference guide and comparison of the Health Plans available to employees of participating firms.