2021 HMO Blue 25
Benefit Summary-Commercial Plan
New York State Active Employees/Retirees

	In-Network Benefits
Plan Features	
Primary Care Physician (PCP)	Required
Referrals	Not Required
Out-of-network benefits	Not covered
Out-of-area benefits	Emergency coverage provided worldwide through the BlueCard® program
Dependent coverage	Qualified dependents covered to 26 (last day of the month following 26th birthday)
Waiting Periods for Pre-Existing Conditions	Does not apply
Plan Cost-Sharing Highlights	
Office visit copay *(PCP)*	$25
Office visit copay *(Specialist)*	$40
Coinsurance	None, unless noted
Deductible	None
Out-of-pocket maximum	Single $6,350 / Family $12,700
Lifetime maximum	None
Plan Benefits	
Preventive Health Care Services	
Well child visits	Covered in full
Adult routine physical exams	Covered in full
Adult immunizations	Covered in full
Routine mammography	Covered in full
Routine Pap smear	Covered in full
Routine GYN exam	Covered in full
Prostate cancer screening	Covered in full
Routine vision exam	No benefit Discount available through Blue365®
Physician Services	
Diagnostic office visits	$25 PCP copay $40 Specialist copay

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Diagnostic imaging (X-rays, CAT scans, MRI, MRA)	$40 copay
Diagnostic laboratory and pathology including EKG/EEG,	**Covered in full**
Surgery - office	Physician: lesser of $50 copay or 20% coinsurance
Chiropractic care	$40 copay
Allergy tests	$25 PCP copay $40 Specialist copay
Allergy injections	$25 PCP copay $40 Specialist copay
Chemotherapy	$25 copay for IV/injectable chemotherapy, in addition to a $25 copay for the office visit
Radiation therapy	$25 copay
Maternity Services	
Prenatal and postpartum care	Covered in full
Hospital care for mom (including delivery)	Facility: Covered in full Physician: lesser of $200 copay or 20% coinsurance
Newborn nursery care	Covered in full
Prescription Drug Short-term, maintenance and specialty drugs are covered under the following copayments: **Retail:** Limit - 30 day supply. 1 copay per 30 day supply. **Mail Order**: Limit - 90 day supply. 2 copays per 90 day supply . Mail Order is available through Express Scripts. Contraceptive coverage included. Specialty medications after the initial first fill must be purchased from one of our participating specialty pharmacies.	Retail and Mail Order: 3-Tier Option Tier 1: $10 copay Tier 2*: $30 copay Tier 3*: $50 copay *Tier 2 and tier 3 prescriptions are subject to Maximum Allowable Cost (MAC)

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	In-Network Benefits
Inpatient Hospital Benefits	
Hospital benefits	Covered in full
Physician visits in the hospital	Covered in full
Inpatient Physical Rehabilitation	Covered in full for up to 60 days per calendar year
Surgery	Physician: 20% coinsurance or $200 copay, whichever is less
Anesthesia	Covered in full
Emergency Care	
Emergency room care	$100 copay per visit (Copay waived if admitted inpatient)
Freestanding urgent care center	$35 copay
Ambulance **(Medically necessary ground and air ambulance transportation)**	$100 copay for emergency transportation
Outpatient Hospital Benefits	
Diagnostic imaging **(X-rays, CAT scans, MRI, MRA)**	$40 copay
Diagnostic laboratory and pathology	**Covered in full**
Surgical care	Facility: $50 copay Physician: $40 copay
Chemotherapy	$25 copay
Radiation therapy	$25 copay
Mental Health, Chemical Dependence and Substance Abuse Benefits	
Inpatient mental health care	Covered in full
Outpatient mental health care	$25 copay
Inpatient chemical dependence care	Covered in full (includes detoxification and rehabilitation)
Outpatient chemical dependence care	$25 copay
Inpatient substance abuse rehabilitation	Covered in full

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Other Services	
Diabetic insulin & supplies	$25 copay for a 30-day supply
Skilled nursing facility	Covered in full for up to 45 days per calendar year
Home care	Covered in full for up to 40 visits per calendar year
Hospice	Covered in full for up to 210 days
Outpatient therapy – Physical, Speech and Occupational	$40 copay Limit: 30 visits per calendar, combined benefit
Durable medical equipment & medical supplies	Covered at 50%
External prosthetics/orthotics	Covered at 50%
Internal prosthetics	Covered in full
Hearing exams (routine and diagnostic)	$40 copay for diagnostic hearing exams $40 copay for routine exam (Limit: once every 12 months)
Hearing aids	Covered in full for up to 2 hearing aids every 3 years for children to age 19 only
Dental	$40 copay for accidental injury to sound natural teeth only
Telemedicine MD Live and Physician	Covered in full

Note: This is not a contract or binding agreement; it is a summary of benefits and services only. For complete benefits and conditions of coverage, please refer to your HMO Blue Member Certificate.

Note: Your Eligibility guidelines may be different from those guidelines listed in the contract. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil service's Web site at www.cs.ny.gov.

Visit our website at ExcellusBCBS.com for our most up-to-date Provider Listing, Prescription Drug Listing and Member Discount programs.