2024 Blue Choice
$25 Copay Option

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.	
Student/Dependent coverage	Dependent to age 26 end of month	
Medical Benefit Management Program & Services	Excellus standard Medical Management programs and services applies to fully insured groups. Incudes diabetic drug utilization management.	
Health & Wellness (Incentive Programs)	ThriveWell	Headspace (Stress Management)
Plan Cost Sharing Highlights		
Office visit copay *(PCP)*	$25 Copay	
Office visit copay *(Specialist)*	$40 Copay	
Coinsurance	See Benefit	
Deductible	None	
Out of pocket maximum - Standard Option	Single: $6,350 / Family: $12,700	
Plan Benefits		
Preventive Healthcare Services		
Well child visits	Covered in full	
Adult routine physical exams	Covered in full	
Adult immunizations+	Covered in full	

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Mammography+	Covered in full
Pap smear+	Covered in full
Routine GYN Exam	Covered in full
Prostate cancer screening	Covered in full
Eye Exam Diagnostic	$40 Specialist Copay
Eye Exam Routine	$40 Specialist Copay. 1 exam per plan year for children to age 19; 1 exam once every 2 plan years for adults.
Pediatric Eyewear (Frames/Lenses or Contact Lenses)	50% Coinsurance. 1 Pair per calendar year
Adult Eyewear (Frames/Lenses or Contact Lenses)	$60 1 Pair once every 2 calendar years
Physician's Office Services	
Diagnostic office visits	$25 PCP copay/$40 specialist copay
Telemedicine program	Covered in Full for eligible visits
Telehealth	$25 PCP copay/$40 specialist copay
Diagnostic x-rays	$40 copay
Diagnostic laboratory and pathology	$25 copay
Allergy tests	$25 PCP copay/$40 specialist copay
Allergy injections	$25 PCP copay/$40 specialist copay
Chemotherapy	IV/Injectable chemotherapy will be covered with a $25 copay on the drug, in addition to a $25 office visit copay
Radiation therapy	$25 copay per visit

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Maternity Services	
Prenatal and postpartum care	Prenatal is Covered in Full Postnatal is inclusive in the maternity
Hospital care for mom (including delivery)	Facility: Covered in full after a $100 copay – unlimited days Physician: 20% coinsurance or $200 copay, whichever is less
Newborn nursery care	Covered in full
Prescription Drug Short-term and maintenance drugs are covered up to a 90-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through Express Scripts mail order pharmacy. Contraceptives included.	$10/30/50 Does not include $0 generic for kids. Max applies to Generics and Brand. Patient Assurance Program NYS $100 Insulin Maximum (mandate)
Inpatient Hospital Benefits	
Hospital benefits	Covered in full after a $100 copay per admission for unlimited visits
Physician visits in the hospital	Covered in full
Inpatient Physical Rehabilitation	Covered in full after a $100 copay for up to 60 days per calendar year.
Surgery	Facility: Covered in full after a $100 copay Physician: 20% coinsurance or a $200 copay, whichever is less
Anesthesia	Covered in full
Emergency Care	
Emergency room care	$100 copay per visit

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Freestanding urgent care center	$35 copay
Ambulance	$100 copay for emergency transportation.
Outpatient Hospital Benefits	
Diagnostic x-rays	$40 copay
Diagnostic laboratory and pathology	$25 copay
Surgical Care	Facility: $50 copayment Physician: $40 copayment
Chemotherapy	$25 copay per visit
Radiation Therapy	$25 copay per visit
Mental Health and Chemical Dependence Benefits	
Inpatient mental health care	Covered in full after a $100 copay; unlimited days
Outpatient mental health care	$25 copay
Substance Use Detoxification, Rehabilitation, and Residential Care	$100 copay; unlimited days per admission
Substance Use Treatment	$25 copay; unlimited visits
Additional Benefits	
Diabetic insulin & supplies	$25 copay
Skilled nursing facility	$100 copay for up to 45 days per calendar year. 360-day lifetime maximum
Home care	Covered in full for up to 40 visits per calendar year.
Hospice	Covered in full after a $100 copay for 210 days
Outpatient therapy	$40 copay for up to 30 visits for physical, speech and occupational therapy combined.

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Durable medical equipment	Covered at 50%
External prosthetics	Covered at 50%
Chiropractic	$40 copay
Acupuncture	Not Covered
Dental	Covered same as similar services under benefit plan for accidental injury to sound natural teeth.
Hearing Evaluation Diagnostic and Routine	$40 Specialist copay
Hearing Aids	$40 copay for fitting visit. 2 hearing aids once every 3 years.
Infertility Care State Mandate: if inpatient hospital or medical/surgery covered	Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office Visit benefit. There are no age restrictions, and the benefit includes fertility preservation when a medical treatment will directly or indirectly lead to iatrogenic infertility. Three cycles of in-vitro fertilization per lifetime.

This is not a contract or binding agreement, but a summary of benefits and services. You should rely on your member contract as the complete description of your rights, responsibilities and benefits available under your benefit plan. In the event of a dispute between this summary and your member contract, the member contract will control.

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