BLUEPREFERRED PPO®

MOH BOCES
$10 Copay/$0 Deductible

Excellus BlueCross BlueShield

A nonprofit independent licensee of the BlueCross BlueShield Association

Benefit	In-Network	Out-of-Network
• Coinsurance	100%	20%
• Copayment	$10	None
• Deductible Levels	$0	$100/$300
• Coinsurance Maximum	None	$1,000/$2,500
Hospital/Facility Benefits		
Hospital - Inpatient		
• Unlimited Days Semi-private Room & Board*	Covered In Full	Deductible/Coinsurance
• Maternity Care*	Covered In Full	Deductible/Coinsurance
• Routine Newborn Nursery Care	Covered In Full	Deductible/Coinsurance
Hospital/Facility Outpatient		
• Ambulatory Surgery	Covered In Full	Deductible/Coinsurance
• Pre-admission Testing	Covered In Full	Deductible/Coinsurance
• Kidney Dialysis	Covered In Full	Deductible/Coinsurance
Professional And Additional Health Benefits		
Physician:		
• Office Visit/Consultation	OV Copay	Deductible/Coinsurance
• Chiropractic Services	OV Copay	Deductible/Coinsurance
• Routine Pap Smear	Covered in Full	Deductible/Coinsurance
• Routine Mammography Screening	Covered in Full	Deductible/Coinsurance
• Allergy Testing	OV Copay	Deductible/Coinsurance
• Allergy Injections	Covered in Full	Deductible/Coinsurance
• Second Surgical Opinion/Second Medical Opinion	OV Copay	Deductible/Coinsurance
• Pre/Post Natal Care	Covered In Full	Deductible/Coinsurance
• In-Hospital/In-Facility Physician Services/Consultation	Covered In Full	Deductible/Coinsurance
• Anesthesia	Covered In Full	Deductible/Coinsurance
• Gynecological Visits	OV Copay	Deductible/Coinsurance
Preventive:		
• Annual Routine Physical (1 per year)	OV Copay	Not Covered
• Well-Child Care Visits/Immunizations Up To Age 19	Covered in Full	Covered in Full
• Routine Gynecological Exam (1 per year)	Covered in Full	Deductible/Coinsurance
• Routine Eye Exam (1 per year)	OV Copay	
Alcohol/Substance Abuse:		
• Outpatient Alcohol/Substance (60 Visits/20 For Family Therapy)	Covered In Full	Deductible/Coinsurance
• Inpatient Detoxification and Treatment of Alcohol and Substance Abuse (37 days)*	Covered In Full	Deductible/Coinsurance
Mental Health:		
• Outpatient Mental Health (60 visits per year)	Covered up to 60 visits per calendar year. Subject to a $10 copay per visit-Effective 1/1/07. Prior to 1/1/07 subject to a $25 copay per visit. Services can be provided in an outpatient facility or in a provider's office.	Deductible/Coinsurance
• Inpatient Facility (60 days)*	Covered in full for up to 60 days per calendar year.	
• Inpatient Professional (60 visits)*	Covered in full for up to 60 visits per calendar year.	Deductible/ Coinsurance

Karl Heil 6/3/2020

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	In-Network	Out-of-Network
General Services:		
• Diagnostic Machine Test	Covered In Full	Deductible/Coinsurance
• Diagnostic X-Ray	Covered In Full	Deductible/Coinsurance
• Diagnostic Laboratory	Covered In Full	Deductible/Coinsurance
• Chemotherapy/Radiation	Covered In Full	Deductible/Coinsurance
• Ambulance (ground)	Covered In Full	Covered In Full
• Ambulance (air)	Covered In Full	Covered In Full
• Diabetes, Education, Equipment & Supplies	OV Copay	Deductible/Coinsurance
• Hospice (210 days)	Covered In Full	Deductible/Coinsurance
• Home Health Care (365 visits)*	Covered In Full	Deductible/Coinsurance
• MRI/MRA	Covered In Full	Deductible/Coinsurance
• Infusion Therapy*	Covered In Full	Deductible/Coinsurance
• Skilled Nursing Facility (120 days)*	Covered In Full	Deductible/Coinsurance
• DME and Prosthetic Devices	Covered In Full	Deductible/Coinsurance
• Short Term Therapies		
PT, OT, ST, Cardiac Rehab, Pulmonary Therapy	OV Copay	Deductible/Coinsurance
• Family Planning	Covered In Full	Deductible/Coinsurance
Artificial Insemination	50% Coinsurance	Deductible/50% Coinsurance
Emergency Services:		
• Medical Emergency/Accidental Injury	$35 Copay per visit	Deductible/Coinsurance
Other:		
• Student / dependent coverage to age 25		
• Waiver of Pre-existing Condition Waiting Period		

Prescription Drugs:

• Retail	Mail Order
$5/$10	$0
$10/$20	$10/$20
$5/$15/$30	$10/$30/$60
$10/$20/$35	$20/$40/$70

* Pre-Authorization Required.

This is a summary of benefits to be used for comparison only.
Please refer to the BluePreferred-PPO contract for a complete description of available benefits.