Excellus

Excellus BluePPO

$5/$25/$50

Benefit Time Period: 06/01/2024 - 05/31/2025

Lewis County

General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$250	$750	
Deductible - Family	$0	$750	$2,250	Each individual does not exceed the single deductible.
Coinsurance	0%	0%	20%	
Annual Out of Pocket Maximum - Single	$2,000	$2,000	$2,200	Out-of-pocket maximums accumulate the coinsurance amount and include the deductible, medical copays, including carry over deductible if applicable.
Annual Out of Pocket Maximum - Family	$4,000	$4,000	$4,400	Out-of-pocket maximums accumulate the coinsurance amount and include the deductible, medical copays, including carry over deductible if applicable.

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$0 Copayment	$25 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$0 Copayment	$30 Copayment	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year				Plan Year Benefits
Diabetic Preauthorization and Step Therapy				No

Who is Covered

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Yes

Inpatient Services

Inpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	$200 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	In-Network Inpatient Services are subject to deductible then copayment applies.
Mental Health Care	Covered in Full	Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	$200 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	120 Days Per Plan Year In-Network Inpatient Services are subject to deductible then copayment applies. Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	$200 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days per year In-Network Inpatient Services are subject to deductible then copayment applies. Limits are combined INN and OON.
Maternity Care	Covered in Full	$200 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	In-Network Inpatient Services are subject to deductible then copayment applies.

Inpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	$100 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	In network deductible applies then copayment.
Diagnostic X-ray	Covered in Full	Covered Subject to Deductible	20% Coinsurance Subject to Deductible	Charges $250 & below = $25 copay. Charges above $251= $100 copay. PET Scans = Covered in Full.
Diagnostic Laboratory and Pathology	Covered in Full	$30 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	Covered in Full Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	$25 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	In network deductible applies then copayment. Includes Partial Hospitalization • NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Care	Covered in Full	$25 Copayment Subject to Deductible	20% Coinsurance Subject to Deductible	In network deductible applies then copayment. Includes Partial Hospitalization • NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	$30 Copayment	20% Coinsurance Subject to $50 Deductible	40 Visits Per Calendar Year Limits are combined INN and OON.
Home Infusion Therapy	Covered in Full	$30 Copayment	20% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	PCP - $25 Copayment Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	Charges $250 & below = $25 copay. Charges above $251= $100 copay. PET Scans = Covered in Full.
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP - $25 Copayment Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - Covered in Full	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	• NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - $0 Copayment	PCP - $25 Copayment Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - $10 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.
Chiropractic Care	PCP/Specialist - $25 Copayment	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	20 Visits per year

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - Covered in Full	PCP - $25 Copayment Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Covered in Full	$30 Copayment	20% Coinsurance Subject to Deductible	45 Visits Per Plan Year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	Covered in Full	$30 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	Covered in Full	$30 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam Per Plan Year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	$30 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$35 Copayment	$100 Copayment	$100 Copayment	ER Copay: $35 @ Lewis County General; $100 Elsewhere

Transportation

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Covered in Full	Covered in Full	Covered in Full	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	$25 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Covered Subject to $25 Deductible	Covered Subject to $25 Deductible	Covered Subject to $25 Deductible	$28 Per Exam Every 12 Months $25/$50 Deductible combined with eyewear (Does not combine with Medical deductible). 1 Exam/12months. Max benefit $28/exam. Limits are combined INN and OON.
Pediatric Eyewear - Routine	Covered in Full	0% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Pair per plan year $25/$50 Deductible combined with eyewear (Does not combine with Medical deductible). Limits are combined INN and OON.
Adult Eye Exams - Routine	Covered Subject to $25 Deductible	Covered Subject to $25 Deductible	Covered Subject to $25 Deductible	$28 Per Exam Every 12 Months $25/$50 Deductible combined with eyewear (Does not combine with Medical deductible). 1 Exam/12months. Max benefit $28/exam. Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	Covered	Frames: 1 set every 24 months. $12 allowance. Lenses per 12 months - Single Vision: $14.40 allowance. Bifocal Single: $26.40 allowance. Bifocal Double: $50.40 allowance. Trifocal: $38.40 allowance. Progressive Lense: $50.40/pair. Lenticular: $112 allowance. Contact Lenses: $112 allowance every 12 months. $25/50 Deductible combine with Vision Exam (does not combine with medical deductible). Limits combined IN & OON.

Rx Benefits

Rx Plan

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Rx Plan				$5/$25/$50

Rx Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30	30		
Days Supply Per Mail Order	90	90		
Copays Per Mail Order Supply	1	1		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.