Excellus

Excellus BluePPO Signature Deduct 3

$5/$45/$90 Integrated Rx $0 Generics for Kids

Benefit Time Period: 01/01/2022 - 12/31/2022

HERITAGE CHRISTIAN SERVICES

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$1,800	$1,980	
Deductible - Family	$3,600	$3,960	
Coinsurance	10%	20%	
Annual Out of Pocket Maximum - Single	$3,600	$3,960	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$7,200	$7,920	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$7,920	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Days per contract year Limits are combined INN and OON.
Physical Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 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	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40 visits per contract year
Home Infusion Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Infusion Therapy	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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

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

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	10 Visits per contract year
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$45/$90 Integrated Rx $0 Generics for Kids

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

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.