Excellus

Cayuga Partners Plan -EPO

Domestic $2.50/$10/$25, In Network $15/$60/$85

Benefit Time Period: 01/01/2025 - 12/31/2025

Cayuga Medical Center

General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$1,000	Not Covered	
Deductible - Family	$0	$3,000	Not Covered	Each Individual does not exceed the single deductible, to a maximum of $3,000 per family.
Deductible Aggregation - Single and Family				Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible. Individual
Coinsurance	0%	50%	Not Covered	
Annual Out of Pocket Maximum - Single	$2,000	$6,000	Not Covered	Out-of-pocket maximums accumulate the coinsurance amount , copay and rx copay amounts and include the deductible, including carry over deductible if applicable.
Annual Out of Pocket Maximum - Family	$4,000	$12,000	Not Covered	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 Aggregation - Single and Family				Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Cost Share - Specialist	$30 Copayment	50% Coinsurance Subject to Deductible	Not Covered	

Plan Limits

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

Who is Covered

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

Inpatient Services

Inpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Substance Use Detoxification	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Skilled Nursing Facility	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	120 Days per year Limits are combined Domestic and INN.
Physical Rehabilitation	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	60 Days per year Limits are combined Domestic and INN.
Maternity Care	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	

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 - 50% Coinsurance Subject to Deductible	Not Covered	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	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	$30 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	$30 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic Laboratory and Pathology	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Radiation Therapy	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Chemotherapy	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Infusion Therapy Outpatient	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Dialysis	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	Covered in Full	Covered in Full	Not Covered	Includes Partial Hospitalization
Substance Use Care	Covered in Full	Covered in Full	Not Covered	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	40 Visits per year Limits are combined Domestic and INN.
Home Infusion Therapy	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	

Hospice Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Infusion Therapy Services	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Dialysis	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Telehealth	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - $25 Copayment	Not Covered	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	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	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year Includes aggregate of visits for Domestic and In-Network of professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Rehabilitation	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year Includes aggregate of visits for Domestic and In-Network of professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Rehabilitation	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	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	Not Covered	1 Exam per year Routine lab and x-ray benefit, billed by another provider as a result of a routine physical: Domestic & INN Covered in Full. OON - Deductible/Coinsurance
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	

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	Not Covered	
Mammography Screening Facility	Covered in Full	Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	Not Covered	
Bone Density Screening Facility	Covered in Full	Covered in Full	Not Covered	

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	Not Covered	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Colonoscopy Screening Professional	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Diagnostic bone density is covered same as diagnositic x-ray.

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	50% Coinsurance Subject to Deductible	Not Covered	
Colonoscopy Screening Facility	$30 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Bone Density Screening Facility	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	Diagnostic bone density is covered same as diagnositic x-ray.

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $20 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - $20 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $20 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Durable Medical Equipment (DME)	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Medical Supplies	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
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	$200 Copayment	$200 Copayment	$200 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$75 Copayment	$75 Copayment	$75 Copayment	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	$35 Copayment	Not Covered	For services at Cortland Convenient Care, copay only applies to professional CMA Medical Practice PLLC. Cayuga Medical facility is covered in full.

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	1 Exam every year Limits are combined Domestic and INN.
Pediatric Eyewear - Routine	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	1 Pair per calendar year Includes Frames/Lenses or Contact Lenses
Adult Eye Exams - Routine	$20 Copayment	50% Coinsurance Subject to Deductible	Not Covered	1 Exam every year Limits are combined Domestic and INN.
Adult Eyewear - Routine	Covered	Covered	Not Covered	$60 Reimbursement every year Includes Frames/Lenses or Contact Lenses

Rx Benefits

Rx Plan

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Rx Plan				Domestic $2.50/$10/$25, In Network $15/$60/$85

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	2	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.