Excellus

Cayuga Partners Plan -EPO

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

Benefit Time Period: 01/01/2024 - 12/31/2024

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 - Two Person	$0	$2,000	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.
Services that Apply to Deductible				Medical Only
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
Deductible Aggregation - In Network and Out of Network				Domestic and In Network aggregate together; Out of Network aggregates separately
Deductible Carryover Months	No	No	No	
History Credit	No	No	No	
Coinsurance	0%	50%	Not Covered	
Annual Out of Pocket Maximum - Single	$2,000	$5,900	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 - Two Person	$4,000	$11,800	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	$11,800	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.
Services that Apply to Out of Pocket Maximum				Medical plus drug
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
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network				Domestic and In Network aggregate together; Out of Network aggregates separately

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Cost Share - Specialist	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	

Plan Limits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Limits Aggregation - In-network and Out of Network				In Network and Out of Network aggregate together
Annual Maximum				Unlimited
Lifetime Benefit Maximum				Unlimited
Kids Copay Age Limit				Does Not Apply
Kids Copay Age Applies To				Does Not Apply
Kids Copay Network				N/A
Referrals Required				No
HSA Funding for Single Tier				$0
HRA Funding for Single Tier				$0
Plan/Calendar Year				Calendar Year Benefits
Coordination of Benefits				Made Whole
Prior Authorization				Prior Authorization applies to In Network Inpatient Excluding Maternity and Emergency Admission Only. When no prior authorization is called in, members will be held harmless for any in-network only non-notification penalties. Applies
Preauthorization - Vendor Managed				This plan requires prior authorization for Radiology, Cardiac Services & Devices, and Radiation Therapy services through eviCore healthcare. All
Diabetic Preauthorization and Step Therapy				Yes
Patient Assurance Program				Applies
Medication Assurance Program				Applies
Prior Authorization - Medical Specialty Drugs				Applies

Precertification

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
PreCertification				All inpatient admissions (excluding maternity), home health, infusion therapy, DME, organ transplants, MRI, and CAT/ PET scans, Autism Assistive Communication Devices (ACD). Applies
PreCertification Penalty				50% of Coinsurance up to $500
All Inpatient Excluding Maternity and Emergency Admission				Applies OON Only
Organ Transplants				Applies
Autism Assistive Communication Devices				Applies over $200 only
Home Care				Applies
Outpatient Surgery				Does not apply
Outpatient Mental Health Care and Substance Use Treatment				Does not apply
Air Ambulance				Does not apply
Cardiac Rehabilitation				Does not apply
Covered Therapies				Does not apply
Physical Therapy				Does not apply
Sleep Apnea and Pain Management				Does not apply
Services by a Specialist				Does not apply
DME				Applies over $200 only
External Prosthetics				Applies
Advanced Imaging Services				Applies
Magnetic Resonance Imaging (MRI) Services				Applies
CAT Scans				Applies
PET Scans				Applies
Hospice Care				Does not apply
Reproductive Services				Does not apply

Who is Covered

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Type of Tiers				2 Tier (EE / FAM)
Dependent Coverage				Age to which all dependents (excluding spouse) are covered Dependent To Age 26
Dependent Age End Period				Age to which all dependents (excluding spouse) are covered End of Month

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

Additional Group Characteristics

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Total Employees				959
Total Eligible				0
Group Size				Large Group
Funding Arrangement				ASC
FMHP Exempt				No
Retiree Only				No
Sovereign Nation				No
Religious Group				No
Grandfathered				No

Allowable Expense

Allowable Expense

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility in Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate		
Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge		
Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge		
Professional Healthcare Provider Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge		
Emergency Facility in Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	Air Ambulance In Area we allow lesser of 130 Percent of Medicare Allowance.
Emergency Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	Air Ambulance Out Area we allow lesser of 130 Percent of Medicare Allowance.
Emergency Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Emergency Professional Healthcare Provider Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance In Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area Within NYS		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area Outside of NYS		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow 100 Percent of Charge.	
Air Ambulance In Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Air Ambulance Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Dialysis Facility in Area		Negotiated Amount. Member's cost share is based on Charge if Lower than Negotiated Rate		
Dialysis Facility Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider In Area		Lower of Negotiated Amount or Charge		
Dialysis Professional Healthcare Provider Out of Area		Lower of Negotiated Amount, Blue Card Allowance or Charge	We allow the lesser of 100 Percent of Negotiated Amount, 100 Percent of Blue Card allowance or 100 Percent of Charge.	

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	
Mental Health Residential Care	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Substance Use Detoxification	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Substance Use Rehabilitation	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Substance Use Residential Care	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	
Routine Newborn Nursery Care	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Prosthetic - Implanted Devices	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Mastectomy	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Observation Stay	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
In Hospital Physician Visits and Consults	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	

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	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Colonoscopy Facility Diagnostic	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Preadmission Pre-Operative Testing	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	Must be done 7 days prior to admission ,Physician other than surgeon.
Diagnostic X-ray	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Routine X-ray	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	
Advanced Imaging Services	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic Laboratory and Pathology	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Routine Laboratory and Pathology	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Diagnostic Testing	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	Inclusive of Primary Service	Inclusive of Primary Service	Not Covered	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Injectable Drugs	Inclusive of Primary Service	Inclusive of Primary Service	Not Covered	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
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
Opioid Treatment Program		Covered in Full		
Autism Applied Behavior Analysis	Covered in Full	Covered in Full	Not Covered	
Substance Use Family Counseling	Covered in Full	Covered in Full	Not Covered	Includes Partial Hospitalization
Pulmonary Rehabilitation	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year Limits are combined for Domestic & INN
Cardiac Rehabilitation	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	

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	
Hospice Care Outpatient	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	
Family Bereavement	Covered in Full	50% Coinsurance Subject to Deductible	Not Covered	5 Visits per year

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Outpatient Hospital and Ambulatory Surgery	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Office Surgery	PCP/Specialist - $15 Copayment	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
Colonoscopy Professional Diagnostic	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Routine X-ray	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Advanced Imaging Services	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	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	
Routine Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diagnostic Testing	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	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Not Covered	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Injectable Drugs	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Not Covered	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Substance Use Treatment	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Opioid Treatment Program		PCP/Specialist - Covered in Full		
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Autism Applied Behavior Analysis	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Additional Surgical Opinion	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Second Medical Opinion for Cancer	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Pulmonary Rehabilitation	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year Limits are combined for Domestic and INN.
Cardiac Rehabilitation	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Office Visits - Diagnostic	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties e.g. GYN, cardiac, orthopedists, etc. are included. This also includes eye exams or hearing exams for the diagnosis or treatment of illness or injury. Office visits may include house calls.
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
Medications Administered in Office	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Not Covered	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Hearing Evaluations Diagnostic	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Chiropractic Care	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Allergy Testing	PCP/Specialist - $15 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
Adult Hearing Aids	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit				Does Not Apply
Pediatric Hearing Aids	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Cochlear Implants	PCP/Specialist - Covered in Full	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$15 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	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Rehabilitation	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Physical Habilitation	$15 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 Habilitation	$15 Copayment	50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Habilitation	$15 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/Specialist - $15 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/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Physical Habilitation	PCP/Specialist - $15 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 Habilitation	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	45 Visits per year
Speech Habilitation	PCP/Specialist - $15 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	
Family Planning	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
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/Specialist - $15 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	$15 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 Insulin and Supplies	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Education	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diabetic Equipment	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Diabetic Retail Max Day Supply	90	90		
Diabetic Retail Copay for Max Day Supply	$15 Copayment	$15 Copayment		
Diabetic Mail Order Max Day Supply	90	90		
Diabetic Mail Order Copay for Max Day Supply	$15 Copayment	$15 Copayment		
Autism Assistive Communication Device	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Autologous Blood Banking	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Mastectomy Prosthesis	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Orthotics	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Foot Orthotics	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Prosthetic - External Benefit	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - $15 Copayment	PCP/Specialist - $25 Copayment	Not Covered	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	1 Rental or Purchase per pregnancy Includes Electrical pumps
Acupuncture	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Reproductive Services	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

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
PUVA Treatment	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Nutritional Therapy	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	
Biofeedback	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	

Diagnoses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Accidental Dental	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Dental Oral Surgery	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Temporomandibular Joint (TMJ)	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Nutritional Counseling	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Infertility Care	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	Coverage for the diagnosis and treatment (surgical and medical) of infertility. Effective 1/1/2024, upon group renewal there are no age restrictions and the benefit now includes fertility preservation when a medical treatment will directly or indirectly lead to iatrogenic infertility and 3 cycles of in-vitro fertilization.
Organ and Bone Marrow Transplants	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Elective Sterilization - Female	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Elective Sterilization - Male	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Interruption of Pregnancy	PCP/Specialist - Included	PCP/Specialist - Included	Not Covered	
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Custom Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Gene Therapy, CAR-T Therapy & Anti-Amloid Agents	Not Covered	Not Covered	Not Covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.
Allogenic Processed Thymus Tissue & Hypoplasminogenemia Agents	Not Covered	Not Covered	Not Covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.

Emergency Services

ER Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$75 Copayment	$75 Copayment	$500 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

ER Professional

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	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	
Air Ambulance	$75 Copayment	50% Coinsurance Subject to Deductible	50% Coinsurance Subject to $1,000 Deductible	Out of Network Air Ambulance Limited to 130 Percent of Medicare Allowance.
Intra Hospital Transportation	$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	

Urgent Care - Professional

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Physician Office Visit for Urgent Care	PCP/Specialist - $15 Copayment	PCP/Specialist - 50% Coinsurance Subject to Deductible	Not Covered	

Total Health Management Programs

Medical Management Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Case Management Program				Applies Yes
Case Management Behavioral Health Program				Applies Yes
Disease Management Program				Applies Yes

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Health Promotion				Applies Yes

Wellness Programs

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Certified Partners				N/A
Surgery Decision Program				N/A

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pediatric Vision Age Limit				19
Pediatric Eye Exams - Routine	$15 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	$15 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
$0 Generics for Kids	No	No		
Generics for Kids Age Limit	Does Not Apply	Does not apply		
MAC Penalty	Yes	Yes		
Step Therapy	Yes	Yes		
Prior Authorization	Yes	Yes		
Oral Contraceptives		Included - Generics CIF		

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Mandatory MO for Maintenance Drugs	No	No		
Days Supply Per Retail Order	30	30		
Days Supply Per Mail Order	90	90		
Copays Per Mail Order Supply	2	2		
Deductible	$0	$0		
Family Deductible	$0	$0		
Deductible applies to	All	All		
Embedded Rx	No	No		
Annual benefit maximum	Integrated with Medical	Integrated with Medical		
Benefit maximum applies to	All	All		
OOP Maximum	Integrated with Medical	Integrated with Medical		
OOP Maximum Applies to	All	All		

Exclusions

Exclusions

Benefit Name	Excluded
Convalescent and Custodial Care	Yes
Cosmetic Services	Yes
Dental Services	Yes
Experimental or Investigational Treatment	Yes
Felony Participation	Yes
Government Facility	Yes
Medicare or Other Governmental Program	Yes
Military Service	Yes
No-Fault Automobile Insurance	Yes
Services Not Listed	Yes
Services with No Charge	Yes
War	Yes
Workers Compensation	Yes

The group has reviewed the benefit grid 2110470-1 and accepts the benefits as indicated.

Signature of Group Administrator: _____

Date: _____

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.