Excellus

Simply Blue Copay

$5/$25/$50, $0 Gen for Kids

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

MONROE COUNTY

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$500	
Deductible - Family	$0	$1,500	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	N/A	$1,500	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	N/A	$4,500	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$25 Copayment	20% Coinsurance Subject to Deductible	$0 copayment for dependents to age 19 on all In-Network PCP office visits.
Cost Share - Specialist	$40 Copayment	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			Yes

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	$150 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$150 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$150 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$150 Copayment	20% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	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	$75 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$40 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$40 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$25 Copayment	20% Coinsurance Subject to Deductible	Kids apply the same dollar copay as adults. IV/ injectable chemo will apply the copay on the drug in addition to an OV copay. Maximum 2 copays per provider per day - 1 for OV, 1 for injectable.
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	40 Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	Injectable copay applies.
Mental Health Care	$40 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$40 Copayment	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	Covered in Full	20% Coinsurance Subject to $50 Deductible	40 Visits per year Limits are combined INN and OON.
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	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 - $25 Copayment Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	$0 copay for kids to age 19 on all PCP office visits.
Diagnostic X-ray	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	Kids apply the same dollar copay as adults. IV/ injectable chemo will apply the copay on the drug in addition to an OV copay. Maximum 2 copays per provider per day - 1 for OV, 1 for injectable.
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 - Covered in Full	20% Coinsurance Subject to Deductible	Injectable copay applies
Mental Health Care	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP - $25 Copayment Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	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 - $40 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $25 Copayment Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests. $0 Copay for kids to age 19 on all PCP office visits. Excludes the injectable copay benefit.
Allergy Treatment Including Serum	PCP - $25 Copayment Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums). $0 Copay for kids to age 19 on all PCP office visits. Excludes the injectable copay benefit.
Hearing Evaluations Routine	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per 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	$40 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	$40 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$40 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $40 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 - $40 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

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 year Limits are combined INN and OON. HCR Exempt.
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	HCR Exempt.
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	HCR Exempt.
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	HCR Exempt.
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	HCR Exempt.
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	HCR Exempt.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	HCR Exempt.
Bone Density Screening Professional	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	HCR Exempt.

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	$40 Copayment	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 - $40 Copayment	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	$40 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - $25 Copayment	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 - $25 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year Limits combined INN and OON.
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	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	$75 Copayment	$75 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	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$75 Copayment	$75 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$40 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$40 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Covered	Covered	$60 reimbursement per plan year Includes Frames/Lenses or Contact Lenses
Adult Eye Exams - Routine	$40 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	$60 reimbursement per plan year Includes Frames/Lenses or Contact Lenses

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$25/$50, $0 Gen 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.