Excellus

# Excellus BluePPO Signature Copay 1

**$10/$30/$50**

**Benefit Time Period: 01/01/2026 - 12/31/2026**

**Monroe County**

## General Information

### Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Deductible - Single | $0 | $750 | |
| Deductible - Family | $0 | $2,250 | Each Individual does not exceed the single deductible. |
| 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.<br>Individual |
| Coinsurance | 0% | 20% | |
| Annual Out of Pocket Maximum - Single | $4,200 | $4,620 | 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 | $12,600 | $13,860 | 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.<br>Individual |

### Office Visit Cost Shares

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cost Share - Primary Care | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Cost Share - Specialist | $20 Copayment | 20% Coinsurance<br>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 | | | Covered |

## Inpatient Services

### Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Services | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | 120 Days per year<br>360 Days per lifetime. Covered in full if admitted directly from Hospital. |
| Physical Rehabilitation | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | 60 Days per year<br>Limits are combined INN and OON. |
| Maternity Care | $100 Copayment | 20% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance | 20% Coinsurance<br>Subject to Deductible | $100 Maximum Coinsurance Per Service |
| Anesthesia | PCP/Specialist - Covered in Full | 20% Coinsurance<br>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 | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | $50 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | Injectable drugs included |
| Chemotherapy | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | Injectable drugs included |
| Chemotherapy Medications | | | |
| Infusion Therapy Outpatient | Inclusive of Primary Service | Inclusive of Primary Service | |
| Dialysis | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Substance Use Care | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |

## Home and Hospice Care

### Home Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Home Care | Covered in Full | 20% Coinsurance<br>Subject to $50 Deductible | |
| Home Infusion Therapy | Covered in Full | 20% Coinsurance<br>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<br>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 - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | Injectable drugs included |
| Chemotherapy | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | Injectable drugs included |
| Infusion Therapy Services | 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 - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance | 20% Coinsurance<br>Subject to Deductible | $100 Maximum Coinsurance Per Service<br>Complications of Pregnancy and Termination - INN: Covered in Full |
| Telehealth | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>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 - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Allergy Testing | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Allergy Treatment Including Serum | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | |
| Hearing Evaluations Routine | PCP/Specialist - $20 Copayment | Not Covered | 1 Exam per year |

## Rehab and Habilitation

### Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | $20 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | $20 Copayment | 20% Coinsurance<br>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 - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | PCP/Specialist - $20 Copayment | 20% Coinsurance<br>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 | Not Covered | 1 Exam per year |
| Adult Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance<br>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<br>Subject to Deductible | |
| Mammography Screening Facility | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 20% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 20% Coinsurance<br>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 - 20% Coinsurance | 20% Coinsurance Subject to Deductible | $100 Maximum Coinsurance Per Service |
| Bone Density Screening Professional | PCP/Specialist - $20 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 | $50 Copayment | 20% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | $20 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 - $20 Copayment | 20% Coinsurance Subject to Deductible | |
| Treatment of Diabetes - Insulin | PCP/Specialist - $20 Copayment | 20% Coinsurance Subject to Deductible | |
| Diabetic Equipment | PCP/Specialist - 20% Coinsurance | 20% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance | Not Covered | |
| Medical Supplies | PCP/Specialist - Not Covered | Not Covered | Not Covered |
| Acupuncture | PCP/Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits per year |
| 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 | $50 Copayment | $50 Copayment | |

### Transportation

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Prehospital Emergency and Transportation - Ground or Water | $50 Copayment | $50 Copayment | |

### Urgent Care

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

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Pediatric Eye Exams - Routine | $20 Copayment | Not Covered | 1 Exam per year |
| Pediatric Eyewear - Routine | 20% Coinsurance | Not Covered | 1 Pair in any 12-month period |
| Adult Eye Exams - Routine | $20 Copayment | Not Covered | 1 Exam every 2 years |
| Adult Eyewear - Routine | Covered | Covered | $60 Reimbursement in any 12-month period |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Rx Plan | | | $10/$30/$50 |

### 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 | 3 | | |

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.