Excellus

Excellus BluePPO Signature Copay 1

$10/$30/$50

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	$750	
Deductible - Family	$0	$2,250	Each Individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	N/A	$2,650	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	$7,950	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	$20 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 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	$100 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$100 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$100 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$100 Copayment	20% Coinsurance Subject to Deductible	120 Days per year 360 days per lifetime. Covered in full if admitted directly from Hospital.
Physical Rehabilitation	$100 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	$100 Copayment	20% Coinsurance 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 Subject to Deductible	$100 Maximum Coinsurance Per Service
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance 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 Subject to Deductible	
Diagnostic X-ray	$20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$20 Copayment	20% Coinsurance Subject to Deductible	Injectable drugs included
Chemotherapy	$20 Copayment	20% Coinsurance Subject to Deductible	Injectable drugs included
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Care	$20 Copayment	20% Coinsurance 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 Subject to $50 Deductible	
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/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	Injectable drugs included
Chemotherapy	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	Injectable drugs included
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 - $20 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	$100 Maximum Coinsurance Per Service Complications of Pregnancy and Termination - INN: Covered in Full
Telehealth	PCP/Specialist - $20 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 - $20 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - $20 Copayment	20% Coinsurance 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 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	$20 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$20 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 - $20 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 - $20 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $20 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 - $20 Copayment	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 Subject to Deductible	
Routine GYN Visit	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - $5 Copayment	20% Coinsurance Subject to Deductible	$5 copay for the first 10 visits then the remaining visits are Covered in Full.
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 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	$50 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$20 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 - 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 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	Covered	Covered	$60 Reimbursement 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.