Excellus

Finger Lakes Area School Health Plan

# Excellus BluePPO Signature Deduct 3

**$5/$35/$70 Integrated Rx, $0 Generics for Kids**

**Benefit Time Period: 07/01/2023 - ~~06/30/2024~~ 12/31/23**

High dect.

## General Information

### Cost Sharing Expenses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Deductible - Single | $1,500 | $1,650 | |
| Deductible - Family | $3,000 | $3,300 | |
| Coinsurance | 20% | 40% | |
| Annual Out of Pocket Maximum - Single | $3,000 | $3,300 | 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 | $6,000 | $6,600 | 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% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Cost Share - Specialist | 20% Coinsurance Subject to Deductible | 40% 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 | | | Applies |

### 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 | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per contract year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | 20% Coinsurance<br>Subject to Deductible | 40% 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to $1,500 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 | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Infusion Therapy | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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 | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care). |

### Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Hospice Care Inpatient | 20% Coinsurance<br>Subject to Deductible | 40% 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% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| 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% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance<br>Subject to Deductible | Not Covered | Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions. |
| Chiropractic Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Allergy Testing | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>Limits are combined INN and OON. |

## Rehab and Habilitation

### Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract 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% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

### Outpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract 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% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per contract year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |

## 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 | 40% Coinsurance<br>Subject to Deductible | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | 0% Coinsurance | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 40% 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 | 40% Coinsurance Subject to Deductible | |
| Mammography Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 40% 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 | 40% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% 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 | 40% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

## Other Benefits

### Additional Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Treatment of Diabetes Insulin and Supplies | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin. |
| Diabetic Equipment | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Medical Supplies | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 10 Visits per contract 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 - Covered<br>Subject to Deductible | Covered<br>Subject to $1,500 Deductible | $4,000 Reimbursement Per Plan Year<br>Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides. |

## Emergency Services

### ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Facility Emergency Room Visit | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to $1,500 Deductible | 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 | 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to $1,500 Deductible | |

### Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Urgent Care Center Facility Visit | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Pediatric Eye Exams - Routine | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per contract year |
| Pediatric Eyewear - Routine | Not Covered | Not Covered | Not Covered |
| Adult Eye Exams - Routine | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per contract year |
| Adult Eyewear - Routine | Not Covered | Not Covered | Not Covered |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Rx Plan | | | $5/$35/$70 Integrated Rx, $0 Generics 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.