Excellus

Excellus BluePPO

Contraceptives Only

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

Hamilton College

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$300	$1,100	
Deductible - Two Person	$600	$2,200	
Deductible - Family	$900	$2,750	Each individual does not exceed the single deductible.
Services that Apply to Deductible			Medical Only
Deductible Aggregation - Single and Family			Each individual does not exceed single deductible, once family deductible has been met by any number of individuals, deductible is met for all. Individual
Deductible Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	10%	30%	
Annual Out of Pocket Maximum - Single	$1,900	$3,550	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 - Two Person	$3,800	$7,100	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	$5,500	$8,800	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 Only
Annual Out of Pocket Maximum Aggregation - Single and Family			Each individual does not exceed single out-of-pocket maximum, once family out-of-pocket maximum has been met by any number of individuals, out-of-pocket maximum is met for all. Individual
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			In Network and Out of Network aggregate separately

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$25 Copayment	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	$40 Copayment	30% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	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			None
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			No
Patient Assurance Program			Does Not Apply
Medication Assurance Program			Applies
Prior Authorization - Medical Specialty Drugs			Does Not Apply
Meal Home Delivery			

Precertification

Benefit Name	In Network	Out of Network	Limits and Additional Information
PreCertification			Applies
PreCertification Penalty			50% of Coinsurance up to $500
All Inpatient Excluding Maternity and Emergency Admission			Applies OON Only

Benefit Name	In Network	Out of Network	Limits and Additional Information
Organ Transplants			Applies
Autism Assistive Communication Devices			Applies over $200
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
External Prosthetics			Does not apply
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	In Network	Out of Network	Limits and Additional Information
Type of Tiers			4 Tier (EE, EE/SP, EE/Child(ren), 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
Domestic Partner Coverage			Covered

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			616
Total Eligible			0
Group Size			Large Group

Benefit Name	In Network	Out of Network	Limits and Additional Information
Funding Arrangement			ASC
FMHP Exempt			No
Retiree Only			No
Sovereign Nation			No
Religious Group			No
Grandfathered			No

Allowable Expense

Allowable Expense

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of average negotiated amount with participating Facilities of the same type as the non-participating Facilities or 100 Percent of Charge.	If no average negotiated amount then we allow 100 Percent of Charge - OON Only
Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of average negotiated amount with participating Facilities of the same type as the non-participating Facilities, 100 Percent of Blue Card allowance or 100 Percent of Charge.	If no average negotiated amount then we allow 100 Percent of Charge - OON Only
Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 90th Percentile of Fair Health, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed in the Fair Health System, we allow 100 Percent of Charge.	
Emergency Facility in Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Emergency Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance including Interfacility Transfer Out of Area Within NYS	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow 100 Percent of Charge.	
Prehospital Emergency Services and Transport - Ground Ambulance Out of Area Outside of NYS	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow 100 Percent of Charge.	
Air Ambulance In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of Qualified Payment Amount or 100 Percent of Charge.	
Air Ambulance Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	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 the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent of average negotiated amount with participating Facilities of the same type as the non-participating Facilities or 100 Percent of Charge.	If no average negotiated amount then we allow 100 Percent of Charge - OON Only
Dialysis Facility Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 100 Percent of average negotiated amount with participating Facilities of the same type as the non-participating Facilities, 100 Percent of Blue Card allowance or 100 Percent of Charge.	If no average negotiated amount then we allow 100 Percent of Charge - OON Only
Dialysis Professional Healthcare Provider In Area	Negotiated Amount. Member's cost share is based on the Charge if Lower than the Negotiated Amount.	We allow the lesser of 100 Percent In-Network Negotiated Regional Rate or 100 Percent of Charge.	
Dialysis Professional Healthcare Provider Out of Area	Negotiated Amount or Blue Card Allowance. Member's cost share is based on the Charge if Lower than the Negotiated Amount or Blue Card Allowance.	We allow the lesser of 90th Percentile of Fair Health, 100 Percent of Blue Card allowance or 100 Percent of Charge. If the service is not listed in the Fair Health System, we allow 100 Percent of Charge.	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Residential Care	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Substance Use Detoxification	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Substance Use Rehabilitation	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Substance Use Residential Care	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Physical Rehabilitation	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Routine Newborn Nursery Care	10% Coinsurance	30% Coinsurance Subject to Deductible	
Prosthetic - Implanted Devices	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mastectomy	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Observation Stay	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	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 - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	$40 Copayment	30% Coinsurance Subject to Deductible	
Routine X-ray	$40 Copayment	30% Coinsurance Subject to Deductible	
Advanced Imaging Services	$40 Copayment	30% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	30% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	Covered in Full	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Diagnostic Testing	Covered in Full	30% Coinsurance Subject to Deductible	
Radiation Therapy	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Injectable Drugs	Inclusive of Primary Service	Inclusive of Primary Service	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Care	$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Opioid Treatment Program			
Autism Applied Behavior Analysis	$25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Family Counseling	$25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Pulmonary Rehabilitation	$40 Copayment	30% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	$40 Copayment	30% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	10% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	10% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	30% Coinsurance Subject to Deductible	
Hospice Care Outpatient	Covered in Full	30% Coinsurance Subject to Deductible	
Family Bereavement	Covered in Full	30% Coinsurance Subject to Deductible	5 Visits per year

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Outpatient Hospital and Ambulatory Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Office Surgery	PCP - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
Colonoscopy Professional Diagnostic	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Routine X-ray	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Advanced Imaging Services	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans
Mammography Professional Diagnostic	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Routine Laboratory and Pathology	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic Testing	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
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 - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Injectable Drugs	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	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 - $25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Treatment	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Opioid Treatment Program	PCP/Specialist - $25 Copayment		
Maternity Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	NYS Maternal Depression Screening Mandate Applies.
Autism Applied Behavior Analysis	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Additional Surgical Opinion	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Second Medical Opinion for Cancer	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Pulmonary Rehabilitation	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Cardiac Rehabilitation	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Visits - Diagnostic	PCP - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	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 - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full	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.
Medications Administered in Office	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Excludes injections for vaccines, allergy injections & treatment of diabetes.
Eye Exams Diagnostic	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Hearing Evaluations Diagnostic	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered
Adult Hearing Aids	PCP/Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit			Does Not Apply
Pediatric Hearing Aids	PCP/Specialist - Not Covered	Not Covered	Not Covered
Cochlear Implants	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$25 Copayment	30% 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	$25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Physical Habilitation	$25 Copayment	30% 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 Habilitation	$25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Habilitation	$25 Copayment	30% 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 - $25 Copayment	30% 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 - $25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Physical Habilitation	PCP/Specialist - $25 Copayment	30% 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 Habilitation	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Habilitation	PCP/Specialist - $25 Copayment	30% 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	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Visit per year
Family Planning	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	30% 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	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% 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	30% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	NYS Mammography Screening Mandate Applies - One Annual Mammogram for ages 35-39.
Colonoscopy Screening Professional	PCP/Specialist - 10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $40 Copayment	30% 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	30% Coinsurance Subject to Deductible	NYS Mammography Screening Mandate Applies - One Annual Mammogram for ages 35-39.
Colonoscopy Screening Facility	10% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$40 Copayment	30% 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	30% Coinsurance Subject to Deductible	Plan will cover pumps, pump supplies and continuous glucose monitors/transmitters/sensors (ie Guardian, Freestyle Navigator, Seven Plus)
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Plan will cover pumps, pump supplies and continuous glucose monitors/transmitters/sensors (ie Guardian, Freestyle Navigator, Seven Plus)
Diabetic Education	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	Plan will cover pumps, pump supplies and continuous glucose monitors/transmitters/sensors (ie Guardian, Freestyle Navigator, Seven Plus)
Diabetic Retail Max Day Supply	N/A		
Diabetic Retail Copay for Max Day Supply	N/A		
Diabetic Mail Order Max Day Supply	N/A		
Diabetic Mail Order Copay for Max Day Supply	N/A		
Autism Assistive Communication Device	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Autologous Blood Banking	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Mastectomy Prosthesis	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Orthotics	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Foot Orthotics	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prosthetic - External Benefit	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Prosthetic - Wigs External Benefit	PCP/Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Breast Pump Purchase or Rental	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Rental or Purchase per pregnancy
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Reproductive Services	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered
PUVA Treatment	PCP/Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	Covered only if medically necessary
Nutritional Therapy	PCP/Specialist - Not Covered	Not Covered	Not Covered
Biofeedback	PCP - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	Covered only if medically necessary

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Accidental Dental	PCP/Specialist - Included	Included Subject to Deductible	
Dental Oral Surgery	PCP/Specialist - Included	Included Subject to Deductible	
Temporomandibular Joint (TMJ)	PCP/Specialist - Included	Included Subject to Deductible	
Nutritional Counseling	PCP/Specialist - Included	Included Subject to Deductible	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included	Included Subject to Deductible	
Infertility Care	PCP/Specialist - Included	Included Subject to Deductible	Coverage for the diagnosis and treatment (surgical and medical) of infertility. Effective 7/1/2022, 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	Included Subject to Deductible	
Elective Sterilization - Female	PCP/Specialist - Included	Included Subject to Deductible	
Elective Sterilization - Male	PCP/Specialist - Included	Included Subject to Deductible	
Interruption of Pregnancy	PCP/Specialist - Included	Included Subject to Deductible	
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered	Covered	$4,000 Reimbursement Per Plan Year 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	$200 Copayment	$200 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	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	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	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$200 Copayment	$200 Copayment	
Air Ambulance	$200 Copayment	$200 Copayment	
Ambulance - Inter Hospital Transportation	$200 Copayment	$200 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	30% Coinsurance Subject to Deductible	

Urgent Care - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Physician Office Visit for Urgent Care	PCP - $25 Copayment Specialist - $40 Copayment	30% Coinsurance Subject to Deductible	

Total Health Management Programs

Medical Management Services

Benefit Name	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
Health Promotion			Applies Yes

Wellness Programs

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

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Vision Age Limit			Does Not Apply
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
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			Contraceptives Only

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	N/A		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	N/A		
Step Therapy	N/A		
Prior Authorization	N/A		
Oral Contraceptives	Generics CIF - Comp Contraceptive Act		
Mandatory MO for Maintenance Drugs	N/A		
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	N/A		
Deductible	N/A		
Family Deductible	N/A		
Deductible applies to	N/A		
Embedded Rx	No		

Benefit Name	In Network	Out of Network	Limits and Additional Information
Annual benefit maximum	N/A		
Benefit maximum applies to	N/A		
OOP Maximum	N/A		
OOP Maximum Applies to	N/A		

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 2251459-1 and accepts the benefits as indicated.

Signature of Group Administrator: Kimberly S. Hatzinger SPHR SHRM-SCP

Date: December 12, 2024

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.