Excellus
Lifetime Assistance

Benefit Comparison
Benefit Time Period 01/01/2020 - 12/31/2020

Excellus BlueEPO	Excellus BluePPO Signature Deduct 3

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	$500	Not Covered		$1,400	$2,800	
Deductible - Family	$1,500	Not Covered		$2,800	$5,600	
Coinsurance	20%	Not Covered		20%	40%	
Annual Out of Pocket Maximum - Single	$4,200	Not Covered		$3,000	$6,000	
Annual Out of Pocket Maximum - Family	$12,600	Not Covered		$6,000	$12,000	

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	$50 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$65 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	$50 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Yes			Applies

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Who is Covered						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Domestic Partner Coverage			Not Covered			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	Not Covered	120 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per contract year
Physical Rehabilitation	20% Coinsurance Subject to Deductible	Not Covered	60 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year
Maternity Care	20% Coinsurance Subject to Deductible	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,400 Deductible	

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Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Outpatient Facility Services						
Outpatient Facility Services						
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	$65 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Not Covered		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	Covered in Full	10 Out of Network Visits per plan year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$50 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Care	$50 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home and Hospice Care						
Home Care						
Home Care	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	Excellus BlueEPO In Network	Excellus BlueEPO Out of Network	Excellus BlueEPO Limits	Excellus BluePPO Signature Deduct 3 In Network	Excellus BluePPO Signature Deduct 3 Out of Network	Excellus BluePPO Signature Deduct 3 Limits
Hospice Care Inpatient	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Excellus BlueEPO In Network	Excellus BlueEPO Out of Network	Excellus BlueEPO Limits	Excellus BluePPO Signature Deduct 3 In Network	Excellus BluePPO Signature Deduct 3 Out of Network	Excellus BluePPO Signature Deduct 3 Limits
Office Surgery	Specialist - $65 Copayment PCP - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - $65 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Not Covered		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - Covered in Full	Covered in Full	10 Out of Network Visits per plan year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - $10 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Chiropractic Care	PCP / Specialist - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - $65 Copayment PCP - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

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Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Allergy Treatment Including Serum	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	$65 Copayment	Not Covered	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	$65 Copayment	Not Covered	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	$65 Copayment	Not Covered	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per contract year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per plan year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	Excellus BlueEPO In Network	Excellus BlueEPO Out of Network	Excellus BlueEPO Limits	Excellus BluePPO Signature Deduct 3 In Network	Excellus BluePPO Signature Deduct 3 Out of Network	Excellus BluePPO Signature Deduct 3 Limits
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	Not Covered		Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Not Covered		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Not Covered		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Not Covered		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	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Colonoscopy Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - $65 Copayment	Not Covered		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	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	Not Covered		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	20% Coinsurance Subject to Deductible	Not Covered		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$65 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - $50 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance Subject to Deductible	Not Covered	10 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	10 Visits per contract year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

	Excellus BlueEPO			Excellus BluePPO Signature Deduct 3		
ER Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	$300 Copayment	$300 Copayment		20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,400 Deductible	
Transportation						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	$65 Copayment	$65 Copayment		20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,400 Deductible	
Urgent Care						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	$50 Copayment	Not Covered		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

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

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			$10/$50/$100			$5/$35/$70, $0 GEN FOR KIDS INTEGRATED RX, NO DED PREV RX

Rx Benefits

Benefit Name	Excellus BlueEPO In Network	Excellus BlueEPO Out of Network	Excellus BlueEPO Limits	Excellus BluePPO Signature Deduct 3 In Network	Excellus BluePPO Signature Deduct 3 Out of Network	Excellus BluePPO Signature Deduct 3 Limits
Days Supply Per Retail Order	30			30		
Days Supply Per Mail Order	90			90		
Copays Per Mail Order Supply	2			2		

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