LIFETIME ASSISTANCE

Benefit Comparison
Benefit Time Period 01/01/2021 - 12/31/2021

	Excellus BluePPO Signature Deduct 3			Excellus BlueEPO		

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	$1,800	$3,600		$750	Not Covered	
Deductible - Family	$3,600	$7,200		$2,250	Not Covered	
Coinsurance	20%	40%		20%	Not Covered	
Annual Out of Pocket Maximum - Single	$4,000	$8,000		$4,600	Not Covered	
Annual Out of Pocket Maximum - Family	$8,000	$16,000		$13,800	Not Covered	
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$16,000		N/A	N/A	

Office Visit Cost Shares

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

Plan Limits

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

Who is Covered

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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	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	Not Covered	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	Not Covered	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year	20% Coinsurance Subject to Deductible	Not Covered	120 Days per year
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year	20% Coinsurance Subject to Deductible	Not Covered	60 Days per year
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	Not Covered	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Anesthesia	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,800 Deductible		PCP / Specialist - Covered in Full	Not Covered	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	Not Covered	

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

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	

Outpatient and Office Professional Services

Professional Services

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Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Office Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Specialist - $65 Copayment PCP - $50 Copayment	Not Covered	
Diagnostic X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $65 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Radiation Therapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Chemotherapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Not Covered	
Dialysis	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full	10 Out of Network Visits per plan year
Mental Health Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $50 Copayment	Not Covered	
Maternity Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Telehealth	PCP / Specialist - 0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
TeleMedicine Program	PCP / Specialist - 0% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Chiropractic Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $50 Copayment	Not Covered	
Allergy Testing	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Specialist - $65 Copayment PCP - $50 Copayment	Not Covered	
Allergy Treatment Including Serum	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Hearing Evaluations Routine	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year	PCP / Specialist - Not Covered	Not Covered	Not Covered

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Rehab and Habilitation

Outpatient Facility

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

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per year
Speech Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - $65 Copayment	Not Covered	45 Visits per 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	40% Coinsurance Subject to Deductible	1 Exam per plan year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	0% Coinsurance		PCP / Specialist - Covered in Full	Not Covered	
Routine GYN Visit	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	

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

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	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	

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	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Bone Density Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $65 Copayment	Not Covered	

Preventive services in addition to those required under Federal Guidelines - Facility

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

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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $50 Copayment	Not Covered	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $50 Copayment	Not Covered	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Acupuncture	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance Subject to Deductible	Not Covered	10 Visits per year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,800 Deductible		$300 Copayment	$300 Copayment	

Transportation

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Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $1,800 Deductible		$65 Copayment	$65 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$50 Copayment	Not Covered	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per contract year	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per contract year	Not Covered	Not Covered	Not Covered
Adult 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			$5/$35/$70 Integrated Rx Preventive Rx not subject to Deductible			$10/$50/$100

Rx Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	30			30		
Days Supply Per Mail Order	90			90		

Benefit Name	Excellus BluePPO Signature Deduct 3			Excellus BlueEPO		
	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Copays Per Mail Order Supply	2			2		
	1655331 - 1			1679565 - 1		

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.