Excellus

Blue Preferred Cayuga Health Partner

$10/$30/$60

Benefit Time Period: 01/01/2023 - 12/31/2023

CAYUGA MEDICAL ASSOCIATES

General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$1,000	$2,000	One deductible for in and out of network combined.
Deductible - Family	$0	$2,000	$4,000	Each individual does not exceed the single deductible.
Coinsurance	$0	20%	40%	
Annual Out of Pocket Maximum - Single	$4,200	$4,200	$8,400	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	$8,400	$8,400	$16,800	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	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	Domestic	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	Domestic	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Covered

Inpatient Services

Inpatient Facility

1953357-1 08/02/2022 03:15:08

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	200 Days per year
Physical Rehabilitation	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% 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	Domestic	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$150 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	$20 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Chemo Therapy Medications Follow the Domestic Level Copay.
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	$20 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	$30 Copayment	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$20 Copayment	$30 Copayment	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	$20 Copayment	20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	40 Visits per year
Home Infusion Therapy	$20 Copayment	20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 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	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	$750 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	210 Days per year

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $20 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Chemo Therapy Medications Follow the Domestic Level Copay.
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	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	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Covered in Full Subject to Deductible	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 - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP -$20 Copayment Specialist -$30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam Per Year

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year
Speech Rehabilitation	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year
Speech Rehabilitation	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	

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

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP -$20 Copayment Specialist -$30 Copayment	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	Domestic	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $20 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Diabetic Mandate Applies and follows the Domestic Level Copay.
Diabetic Equipment	PCP/Specialist - $20 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - $20 Copayment	PCP/Specialist - $30 Copayment	50% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 50% Coinsurance	PCP/Specialist - 50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - $30 Copayment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	10 Visits per year
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$150 Copayment	$150 Copayment	$150 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$150 Copayment	$150 Copayment	$150 Copayment	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per year
Pediatric Eyewear - Routine	50% Coinsurance	50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	1 Pair per plan year Includes Frames/Lenses or Contact Lenses
Adult Eye Exams - Routine	$30 Copayment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per year

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Eyewear - Routine	Covered	Covered	Covered	$60 Reimbursement per plan year Includes Frames/Lenses or Contact Lenses

Rx Benefits

Rx Plan

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Rx Plan				$10/$30/$60

Rx Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30	30		
Days Supply Per Mail Order	90	90		
Copays Per Mail Order Supply	2	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.