Excellus

BluePoint 3

Benefit Time Period: 06/01/2015 - 05/31/2016

Broome County - HMO Green

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	Not Covered	
Deductible - Two Person	$0	Not Covered	
Deductible - Family	$0	Not Covered	
Services that Apply to Deductible			Medical Only
Deductible Aggregation - Single and Family			Individual
Deductible Aggregation - In Network and Out of Network			In Network & Out of Network aggregate together
Deductible Carryover Months	No	No	
History Credit	No	No	
Coinsurance	0%	Not Covered	
Annual Out of Pocket Maximum - Single	$4,425	$4,425	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	$8,845	$8,845	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	$8,845	$8,845	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			Individual
Annual Out of Pocket Maximum Aggregation - In Network and Out of Network			In Network & Out of Network aggregate together

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$15 Copayment	Not Covered	
Cost Share - Specialist	$15 Copayment	Not Covered	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Limits Aggregation - In-network and Out of Network			In Network & 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			Yes
Employer Deductible Funding Percentage			0%
HSA vs HRA			Does Not Apply
Plan/Calendar Year			Calendar Year Benefits
Coordination of Benefits			Made Whole
Prior Authorization			Applies
PreCertification			Does Not Apply
PreCertification Penalty			Does Not Apply

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Type of Tiers			2 Tier (EE / 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			No

Additional Group Characteristics

Benefit Name	In Network	Out of Network	Limits and Additional Information
Total Employees			
Total Eligible			
Group Size			
Funding Arrangement			ASC
Retiree Only			No
Sovereign Nation			No
Religious Group			No

Benefit Name	In Network	Out of Network	Limits and Additional Information
Grandfathered			No

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$100 Copayment	Not Covered	Single - 3 Inpatient Copays max per calendar year, Family - 5 Inpatient Copays max per calendar year
Mental Health Care	$100 Copayment	Not Covered	30 Days per year $100 Copay per admission Includes day/night care; 2/1 day towards the 30 day max. Maximum is combined with Substance Abuse
Mental Health Residential Care	$100 Copayment	Not Covered	30 Days per year $100 Copay per admission Includes day/night care; 2/1 day towards the 30 day max. Maximum is combined with Substance Abuse.
Substance Use Detoxification	$100 Copayment	Not Covered	7 Days per year
Substance Use Rehabilitation	$100 Copayment	Not Covered	30 Days per year 30 days maximum per calendar year combined with mental health.
Substance Use Residential Care	$100 Copayment	Not Covered	30 Days per year 30 days maximum per calendar year combined with mental health.
Skilled Nursing Facility	$100 Copayment	Not Covered	45 Days per year
Physical Rehabilitation	$100 Copayment	Not Covered	60 Days per year
Maternity Care	$100 Copayment	Not Covered	
Routine Newborn Nursery Care	Covered in Full	Not Covered	
Prosthetic - Implanted Devices	Covered in Full	Not Covered	Subject to 20% coins when not rendered in an In Patient setting
Mastectomy	$100 Copayment	Not Covered	
Observation Stay	$100 Copayment	Not Covered	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP / Specialist - $100 Copayment	Not Covered	Lesser of 20% or $100 copay per procedure
Anesthesia	PCP / Specialist - Covered in Full	Not Covered	
In Hospital Physician Visits and Consults	PCP / Specialist - Covered in Full	Not Covered	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	Not Covered	
Preadmission Pre-Operative Testing	Covered in Full	Not Covered	
Diagnostic X-ray	$15 Copayment	Not Covered	
Routine X-ray	$15 Copayment	Not Covered	
Advanced Imaging Services	$15 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	Covered in Full	Not Covered	
Routine Laboratory and Pathology	Covered in Full	Not Covered	
Diagnostic Testing	Covered in Full	Not Covered	
Radiation Therapy	Covered in Full	Not Covered	
Chemotherapy	Covered in Full	Not Covered	
Infusion Therapy	Inclusive of Primary Service	Not Covered	Is Inclusive of Home Care Benefit and not covered as a separate benefit.
Dialysis	Covered in Full	Not Covered	
Injectable Drugs	Inclusive of Primary Service	Not Covered	Excludes vaccines, allergy injections & treatment of diabetes. Cost share is inclusive of services in which the injection is rendered with.
Mental Health Care	50% Coinsurance	Not Covered	20 Visits per year
Substance Use Care	$15 Copayment	Not Covered	60 Visits per year
Autism Applied Behavior Analysis	Not Covered	Not Covered	Not Covered
Substance Use Family Counseling	$15 Copayment	Not Covered	This benefit is included in the 60 visits per year for Substance Use Care
Pulmonary Rehabilitation	Covered in Full	Not Covered	
Cardiac Rehabilitation	Covered in Full	Not Covered	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Not Covered	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Not Covered	
Hospice Care Outpatient	Covered in Full	Not Covered	
Family Bereavement	Covered in Full	Not Covered	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 - 20% Coinsurance	Not Covered	Less of 20%, or $50 copay per procedure
Office Surgery	PCP / Specialist - 20% Coinsurance	Not Covered	Less of 20%, or $50 copay per procedure
Diagnostic X-ray	PCP / Specialist - $15 Copayment	Not Covered	
Routine X-ray	PCP / Specialist - $15 Copayment	Not Covered	
Advanced Imaging Services	PCP / Specialist - $15 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	Not Covered	
Routine Laboratory and Pathology	PCP / Specialist - Covered in Full	Not Covered	
Radiation Therapy	PCP / Specialist - Covered in Full	Not Covered	
Chemotherapy	PCP / Specialist - Covered in Full	Not Covered	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Not Covered	Is Inclusive of Home Care Benefit and not covered as a separate benefit.
Dialysis	PCP / Specialist - Covered in Full	Not Covered	
Injectable Drugs	PCP / Specialist - Inclusive of Primary Service	Not Covered	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 - 50% Coinsurance	Not Covered	20 visits per year
Substance Use Treatment	PCP / Specialist - $15 Copayment	Not Covered	60 visits per year
Maternity Care	PCP / Specialist - Covered in Full	Not Covered	$15 copay for initial visit, remainder covered in full
Autism Applied Behavior Analysis	PCP / Specialist - Not Covered	Not Covered	Not Covered
Additional Surgical Opinion	PCP / Specialist - $15 Copayment	Not Covered	
Second Medical Opinion for Cancer	PCP / Specialist - $15 Copayment	Not Covered	
Pulmonary Rehabilitation	PCP / Specialist - Covered in Full	Not Covered	
Office Visits - Diagnostic	PCP / Specialist - $15 Copayment	Not Covered	
Medications Administered in Office	PCP / Specialist - $15 Copayment	Not Covered	
Eye Exams Diagnostic	PCP / Specialist - $15 Copayment	Not Covered	
Hearing Evaluations Diagnostic	PCP / Specialist - $15 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - $15 Copayment	Not Covered	
Allergy Testing	PCP / Specialist - $15 Copayment	Not Covered	
Allergy Treatment Including Serum	PCP / Specialist - Covered in Full	Not Covered	
Hearing Evaluations Routine	PCP / Specialist - $15 Copayment	Not Covered	1 Exam per year

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Hearing Aids	PCP / Specialist - Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit			19
Pediatric Hearing Aids	PCP / Specialist - CIF to age 19	Not Covered	
Cochlear Implants	PCP / Specialist - Covered in Full	Not Covered	Subject to 20% coins when not rendered in an in Patient setting.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Occupational Rehabilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Speech Rehabilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Physical Habilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Occupational Habilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Speech Habilitation	$15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Occupational Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Speech Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Physical Habilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Occupational Habilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech
Speech Habilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year Combined for Physical, Occupational, and Speech

Preventive Services

Outpatient Facility and Professional Provider

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year Includes associated labs and x-rays
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Not Covered	
Routine GYN Visit	PCP / Specialist - Covered in Full	Not Covered	
Cervical Cytology Preventative	Covered in Full	Not Covered	
Prostate Cancer Screenings	PCP / Specialist - Covered in Full	Not Covered	
Mammography Preventive Facility	Covered in Full	Not Covered	
Mammography Preventive Professional	PCP / Specialist - Covered in Full	Not Covered	
Bone Density Testing Facility	Covered in Full	Not Covered	
Bone Density Testing Professional	PCP / Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Not Covered	Routine and Diagnostic CIF
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	Not Covered	Routine and Diagnostic CIF
Family Planning	PCP / Specialist - Covered in Full	Not Covered	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	Not Covered	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - $15 Copayment	Not Covered	copay per 30 day supply
Diabetic Education	PCP / Specialist - Covered in Full	Not Covered	
Diabetic Equipment	PCP / Specialist - $15 Copayment	Not Covered	
Autism Assistive Communication Device	PCP / Specialist - Not Covered	Not Covered	Not Covered
Autologous Blood Banking	PCP / Specialist - Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	Not Covered	
Mastectomy Prosthesis	PCP / Specialist - 20% Coinsurance	Not Covered	
Orthotics	PCP / Specialist - 20% Coinsurance	Not Covered	
Foot Orthotics	PCP / Specialist - 20% Coinsurance	Not Covered	
Prosthetic - External Benefit	PCP / Specialist - 20% Coinsurance	Not Covered	
Prosthetic - Wigs External Benefit	PCP / Specialist - Not Covered	Not Covered	Not Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP / Specialist - 20% Coinsurance	Not Covered	
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Accidental Dental	PCP / Specialist - Included	Not Covered	
Dental Oral Surgery	PCP / Specialist - Included	Not Covered	
Temporomandibular Joint (TMJ)	PCP / Specialist - Not Covered	Not Covered	
Nutritional Counseling	PCP / Specialist - Included	Not Covered	Nutritional Counseling CIF
Inherited Metabolic Disorder - PKU	PCP / Specialist - Included	Not Covered	
Infertility Care	PCP / Specialist - Included	Not Covered	
Organ and Bone Marrow Transplants	PCP / Specialist - Included	Not Covered	
Elective Sterilization	PCP / Specialist - Included	Not Covered	
Interruption of Pregnancy	PCP / Specialist - Included	Not Covered	

Custom Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Smoking Cessation	PCP / Specialist - Covered in Full	Not Covered	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
OP Facility Emergency Room Visit	$50 Copayment	$50 Copayment	

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	

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency Services Transportation	$25 Copayment	$25 Copayment	
Air Ambulance	$25 Copayment	Not Covered	Only Medically Necessary
Water Ambulance	Not Covered	Not Covered	Not Covered

Urgent Care Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	Not Covered	

Urgent Care Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	PCP / Specialist - Covered in Full	Not Covered	
Physician Office Visit for Urgent Care	PCP / Specialist - $15 Copayment	Not Covered	

Total Health Management Programs

Medical Management Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Case Management Program			Yes
Case Management Behavioral Health Program			Yes
Disease Management Program			Yes
Health Promotion			Yes

Incentive Programs

Benefit Name	Applies	Additional Information
Gym Membership Reimbursement	No	
Exercise Rewards	No	
HealthyRewards/ActiveRewards	No	
BlueHealthyDollars/UniveraFit Dollars	No	
Blue4U	No	
Other Incentive Plan	No	

Vision and Dental

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	$15 Copayment	Not Covered	1 Exam every 2 years
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered
Pediatric Vision Age Limit			Does Not Apply
Pediatric Eye Exams - Routine	$15 Copayment	Not Covered	1 Exam every 2 years
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered

Dental

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Dental	Not Covered	Not Covered	Not Covered
Pediatric Dental Age Limit			19
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	$15 Copayment	Not Covered	Periodic exams, x-rays, cleanings, flouride treatments and sealants
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	Not Covered

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

Benefit Name	Excluded
War	Yes
Workers Compensation	Yes

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan	DRUG COVERAGE EXCLUDED		

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
$0 Generics for Kids	NA		
Generics for Kids Age Limit	Does not apply		
MAC Penalty	NA		
Step Therapy	NA		
Prior Authorization	NA		
Oral Contraceptives	NA		
Mandatory MO for Maintenance Drugs	NA		
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	1		
Deductible	Subject to NA Deductible		
Family Deductible	Subject to NA Deductible		
Deductible applies to	NA		
Embedded Rx	No		
Annual benefit maximum	NA		
Benefit maximum applies to	NA		
OOP Maximum	NA		
OOP Maximum Applies to	NA		

The group has reviewed the benefit grid 566793-1 and accepts the benefits as indicated.

Signature of Group Administrator: _____

Date: _____

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by theterms 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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.