Excellus

Excellus BluePPO

Drug Coverage Excluded

Benefit Time Period: 01/01/2026 - 12/31/2026

Livingston County / Standard Plan

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$500	
Deductible - Family	$0	$1,250	Each individual does not exceed the single deductible.
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible.
Coinsurance	0%	25%	
Annual Out of Pocket Maximum - Single	$6,850	$7,535	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	$13,700	$15,070	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 - Per Person Cap	$6,850	$15,070	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.
Annual Out of Pocket Maximum Aggregation - Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	25% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 Copayment	25% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	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	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$100 Copayment	25% Coinsurance Subject to Deductible	
Mental Health Care	$100 Copayment	25% Coinsurance Subject to Deductible	
Substance Use Detoxification	$100 Copayment	25% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	25% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	25% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Maternity Care	$100 Copayment	25% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	Covered in Full	25% Coinsurance Subject to Deductible	Out of Network services performed in an In Network Facility covered at the In Network benefit.
Anesthesia	Covered in Full	25% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. Out of Network services performed in an In Network Facility covered at the In Network benefit.

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	25% Coinsurance Subject to Deductible	
Diagnostic X-ray	$20 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	25% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	$20 Copayment	25% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Infusion Therapy Outpatient	Covered in Full	25% Coinsurance Subject to Deductible	
Dialysis	Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	Covered in Full	25% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	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	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	25% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	Includes colonoscopy performed in an office setting. Out of Network services performed in an In Network Facility covered at the In Network benefit.
Diagnostic X-ray	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	Out of Network services performed in an In Network Facility covered at the In Network benefit. In-network professional interpretation is $20 copay.
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	Out of Network services performed in an In Network Facility covered at the In Network benefit.
Radiation Therapy	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Dialysis	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	Coverage only for Employee and Spouse. NYS Maternal Depression Screening Mandate Applies.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Telehealth	PCP/Specialist - $20 Copayment	25% 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 program for medical conditions that are not an emergency condition. Behavioral Health Telemedicine is not covered.
Chiropractic Care	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $20 Copayment	Not Covered	1 Exam per Year

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$20 Copayment	25% 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, occupational and respiratory therapy.
Occupational Rehabilitation	$20 Copayment	25% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$20 Copayment	25% 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 - $20 Copayment	25% 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, occupational and respiratory therapy.
Occupational Rehabilitation	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $20 Copayment	25% 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	Not Covered	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	2 Exams per year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	One Post-Partum Care Home visit covered in full for both In and Out of network.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year Age 40 and older. Includes 3D imaging.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year Age 50 and older.
Bone Density Screening Professional	PCP/Specialist - Covered in Full	25% 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	25% Coinsurance Subject to Deductible	2 Exams per year
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year Age 40 and older. Includes 3D imaging.
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year Age 50 and older.
Bone Density Screening Facility	Covered in Full	25% 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 - $20 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year Covered at age 50. High Risk covered at age 40.
Mammography Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year Includes 3D imaging.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year
Bone Density Screening Professional	PCP/Specialist - Covered in Full	25% 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	25% Coinsurance Subject to Deductible	1 Exam per year Includes 3D imaging.
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per year
Bone Density Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	Limited to a 90 day supply when obtained through a diabetic medical supply provider.
Treatment of Diabetes - Insulin	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	Limited to a 90 day supply when obtained through a diabetic medical supply provider.
Diabetic Equipment	PCP/Specialist - $20 Copayment	25% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 25% Coinsurance	50% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits every year Limits combined INN and OON. Out of Network services does not apply to Out of Pocket maximums
Private Duty Nursing	Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$50 Copayment	$50 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. Copay waived if admitted. Non-Emergent not covered.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$20 Copayment	$20 Copayment	

Urgent Care

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

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$20 Copayment	Not Covered	1 Exam per year
Pediatric Eyewear - Routine	Covered in Full	20% Coinsurance	1 Pair per plan year Includes Frames/Lenses or Contact Lenses
Adult Eye Exams - Routine	$20 Copayment	Not Covered	1 Exams every 2 years
Adult Eyewear - Routine	Covered in Full	Covered in Full	$60 Allowance every year Includes Frames/Lenses or Contact Lenses

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
Days Supply Per Retail Order	N/A		
Days Supply Per Mail Order	N/A		
Copays Per Mail Order Supply	N/A		

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.