Excellus

Excellus BluePPO

$10/$30/$50 Domestic, $25/$50/$90 Non Domestic
Benefit Time Period: 01/01/2019 - 12/31/2019

ROCHESTER REGIONAL HEALTH SYSTEM

General Information

Cost Sharing Expenses

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$0	$1,800	
Deductible - Family	$0	$0	$5,400	Each individual does not exceed the single deductible.
Coinsurance	0%	0%	40%	
Annual Out of Pocket Maximum - Single	$5,000	$5,000	$9,000	Out-of-pocket maximums accumulate the coinsurance amount and include the deductible, including carry over deductible if applicable, and copayment.
Annual Out of Pocket Maximum - Family	$10,000	$10,000	$18,000	Each individual does not exceed the single out of pocket maximum. Out-of-pocket maximums accumulate the coinsurance amount and include the deductible, including carry over deductible if applicable, and copayment. Once family OOP maximum has been met by any number of individuals, OOP maximum is met for all. One OOPM for both Domestic and In-Network combined.

Office Visit Cost Shares

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$30 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 Copay for In-Network
Cost Share - Specialist	$50 Copayment	$150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $50 Copay for In-Network

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				No

Who is Covered

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

Inpatient Services

Inpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$750 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $750 Copay for In-Network.
Mental Health Care	$750 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $750 Copay for In-Network.
Substance Use Detoxification	$750 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $750 Copay for In-Network.
Skilled Nursing Facility	$750 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	120 Days Per Plan Year 360 Days Lifetime Max. Pediatric (up to and including age 18): $750 Copay for In-Network. Limits are combined Domestic, INN and OON.
Physical Rehabilitation	Covered in Full	$2,000 Copayment	40% Coinsurance Subject to Deductible	60 Days per year Pediatric (up to and including age 18): Covered in full for In-network. Limits are combined Domestic, INN and OON.
Maternity Care	$750 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $750 Copay for In-Network.

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 - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-network
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full up to schedule of allowance	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. Pediatric (up to and including age 18): Covered in full for In-network

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	$250 Copayment	$2,000 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $250 Copay for In-Network.
Diagnostic X-ray	$50 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $50 Copay for In-Network. Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Diagnostic Laboratory and Pathology	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-Network.
Radiation Therapy	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Chemotherapy	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
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.

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Dialysis	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Mental Health Care	$30 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 Copay for In-Network. Includes Partial Hospitalization
Substance Use Care	$30 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 Copay for In-Network. Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-network
Home Infusion Therapy	Covered in Full	$90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-network

Hospice Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Not Available	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-network

Outpatient and Office Professional Services

Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network.
Diagnostic X-ray	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network.
Diagnostic Laboratory and Pathology	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network.
Radiation Therapy	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network. 1 copay per visit.
Chemotherapy	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network. 1 copay per visit.
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 -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network. 1 copay per visit.
Mental Health Care	PCP/Specialist - $30 Copayment	PCP/Specialist - $90 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/Specialist Copay for In-Network.
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in full for In-network

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP/Specialist - Not Available	PCP/Specialist - $30 Copayment	40% Coinsurance Subject to Deductible	30 visits per year
Allergy Testing	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network. Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network. Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Available	PCP - $30 Copayment Specialist - $50 Copayment	40% Coinsurance Subject to Deductible	1 Exam every 2 years Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network.

Rehab and Habilitation

Outpatient Facility

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$30 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	30 Visits Per Plan Year Pediatric (up to and including age 18): $30 Copay for In-Network. 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	$90 Copayment	40% Coinsurance Subject to Deductible	30 Visits per year Pediatric (up to and including age 18): $30 Copay for In-Network. Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$30 Copayment	$90 Copayment	40% Coinsurance Subject to Deductible	30 Visits per year Pediatric (up to and including age 18): $30 Copay for In-Network. Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $30 Copayment	PCP/Specialist - $90 Copayment	40% Coinsurance Subject to Deductible	30 Visits per year Pediatric (up to and including age 18): $30 Copay for In-Network. 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 - $90 Copayment	40% Coinsurance Subject to Deductible	30 Visits per year Pediatric (up to and including age 18): $30 Copay for In-Network. Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $30 Copayment	PCP/Specialist - $90 Copayment	40% Coinsurance Subject to Deductible	30 Visits per year Pediatric (up to and including age 18): $30 Copay for In-Network. Includes aggregate of visits for Domestic, INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

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 Plan Year Pediatric (up to and including age 18): Covered in Full for In-Network.
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.

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	Pediatric (up to and including age 18): Covered in Full for In-Network.
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.

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	Pediatric (up to and including age 18): Covered in Full for In-Network.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network. Not performed as part of office visit

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	Pediatric (up to and including age 18): Covered in Full for In-Network
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.
Bone Density Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): Covered in Full for In-Network.

Other Benefits

Additional Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network. Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP -$30 Copayment Specialist -$50 Copayment	PCP - $90 Copayment Specialist - $150 Copayment	40% Coinsurance Subject to Deductible	Pediatric (up to and including age 18): $30 PCP/$50 Specialist Copay for In-Network.
Durable Medical Equipment (DME)	PCP/Specialist - Not Available	PCP/Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Not Available	PCP/Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year Limits combined Domestic, INN and OON.
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	$250 Copayment	$500 Copayment	$500 Copayment	Pediatric (up to and including age 18): $250 Copay for In-Network and Out-of-Network. 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	Not Available	$150 Copayment	$150 Copayment	

Urgent Care

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$50 Copayment	$150 Copayment	40% Coinsurance Subject to Deductible	Pediatric up to and including age 18: $50 Copay for In-Network

Ancillary Benefits

Vision

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	1 Exam Per 2 Plan Years Limits are combined INN and OON. One pair of corrective lenses after cataract surgery covered in full.
Adult Eyewear - Routine	Covered	Covered	40% Coinsurance Subject to Deductible	$60 Allowance every 2 years Includes Frames/Lenses or Contact Lenses
Pediatric Eye Exams - Routine	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	1 Exam Per Plan Year Limits are combined INN and OON. Pediatric (up to and including age 18): Covered in Full for In-Network. One pair of corrective lenses after cataract surgery covered in full.
Pediatric Eyewear - Routine	Covered	Covered	40% Coinsurance Subject to Deductible	$60 Allowance 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/$50 Domestic, $25/$50/$90 Non Domestic

Rx Benefits

Benefit Name	Domestic	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	90	90		
Days Supply Per Mail Order	Not Available	90		
Copays Per Mail Order Supply	Not Available	3		

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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.