Excellus

BluePoint 3

DRUG COVERAGE EXCLUDED

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

Broome County - Red HMO Plan

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	Not Covered	
Deductible - Family	$0	Not Covered	
Coinsurance	0%	Not Covered	
Annual Out of Pocket Maximum - Single	$4,425	$4,425	Out-of-pocket maximums accumulate the coinsurance amount, medical copays, and include the deductible, if applicable.
Annual Out of Pocket Maximum - Family	$8,845	$8,845	

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
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			No

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	Not Covered	
Mental Health Care	Covered in Full	Not Covered	
Substance Use Detoxification	Covered in Full	Not Covered	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Skilled Nursing Facility	Covered in Full	Not Covered	45 Days per year
Physical Rehabilitation	Covered in Full	Not Covered	60 Days per year
Maternity Care	Covered in Full	Not Covered	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	Not Covered	
Anesthesia	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	
Diagnostic X-ray	Covered in Full	Not Covered	
Diagnostic Laboratory and Pathology	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 in the Home Care Benefit and not covered as a separate benefit.
Dialysis	Covered in Full	Not Covered	
Mental Health Care	$15 Copayment	Not Covered	
Substance Use Care	$15 Copayment	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	
Home Infusion Therapy	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	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - $15 Copayment	Not Covered	
Diagnostic X-ray	PCP/Specialist - Covered in Full	Not Covered	
Diagnostic 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 in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	Not Covered	
Mental Health Care	PCP/Specialist - $15 Copayment	Not Covered	
Maternity Care	PCP/Specialist - Covered in Full	Not Covered	$15 Copayment for initial visit, remainder Covered in Full
Telehealth	PCP/Specialist - $15 Copayment	Not Covered	
TeleMedicine Program	PCP/Specialist - Not Covered	Not Covered	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

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together
Occupational Rehabilitation	$15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together
Speech Rehabilitation	$15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together
Occupational Rehabilitation	PCP/Specialist - $15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together
Speech Rehabilitation	PCP/Specialist - $15 Copayment	Not Covered	60 Visits per year Physical, Speech and Occupational Therapy Aggregate Together

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 includes associated labs and x-rays and appropriate routine immunizations
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	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	Not Covered	
Mammography Screening Professional	PCP/Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	Not Covered	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Not Covered	
Mammography Screening Facility	Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Not Covered	
Bone Density Screening Facility	Covered in Full	Not Covered	

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 - Covered in Full	Not Covered	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	Not Covered	

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	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Not Covered	
Bone Density Screening Facility	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	20% Copayment or $15, whichever is Less
Diabetic Equipment	PCP/Specialist - $15 Copayment	Not Covered	20% Copayment or $15, whichever is Less
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	Not Covered	
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

Emergency Services

ER Facility

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

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Covered in Full	Covered in Full	

Urgent Care

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

Ancillary Benefits

Vision

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

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.