Excellus

Excellus BluePPO

Custom Rx

Benefit Time Period: 01/01/2025 - 12/31/2025

CROUSE HOSPITAL - Select Plan

General Information

Cost Sharing Expenses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$200	$200	
Deductible - Family	$0	$500	$500	
Coinsurance	0%	20%	20%	
Annual Out of Pocket Maximum - Single	$1,000	$1,000	$1,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services and Rx Copay. RX Out of Pocket Maximum: $6,000 individual/ $11,700 family not combined with medical Out-of-Pocket Maximum.
Annual Out of Pocket Maximum - Family	$3,000	$3,000	$3,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services and Rx Copays. RX Out of Pocket Maximum: $6,000 individual/ $11,700 family not combined with medical Out-of-Pocket Maximum.

Office Visit Cost Shares

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	

Plan Limits

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

Inpatient Services

Inpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Mental Health Care	Covered in Full	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Substance Use Detoxification	Covered in Full	25% Coinsurance	25% Coinsurance	INN CIF for dependents under 19 yrs of age.
Skilled Nursing Facility	Covered in Full	Covered in Full	20% Coinsurance	120 Days per confinement
Physical Rehabilitation	Covered in Full	Covered in Full	20% Coinsurance	120 Visits per year Combined INN & OON
Maternity Care	Covered in Full	25% Coinsurance	25% Coinsurance	Certified Birthing Centers 25%, no deductible. INN: CIF for dependents under 19 yrs of age.

Inpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Includes PET scans
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Chemotherapy	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	Covered in Full	25% Coinsurance	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Covered in Full	Covered in Full Subject to Deductible	40 Visits per year Visits 41 - 365 Domestic/INN - 20% Coinsurance. OON: 20% Coinsurance, after deductible
Home Infusion Therapy	Covered in Full	Covered in Full	Covered in Full Subject to 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	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full Subject to Deductible	Covered in Full Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Domestic applies to Crouse Physician Network in Offices setting only. Professional interpretation charges domestic/INN CIF and OON is ded/coins
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Domestic applies to Crouse Physician Network in Offices setting only. INN Deductible waived for Genetic Testing. Professional interpretation charges domestic/INN CIF and OON is ded/coins
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	HYPNOTHERAPY - Domestic / INN / OON 50% up to $50. 4 visits/yr. combined, does not apply to Ded or OOP, SMOKING CESSATION - Domestic /INN Covered in Full. Two attempts per year. No coverage OON.
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	
Telehealth	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	20 Visits per year Limits combined INN and OON.

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational
Occupational Rehabilitation	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational
Speech Rehabilitation	20% Coinsurance	20% Coinsurance	20% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational.

Outpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	1 Exam per year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	Covered in Full Subject to Deductible	1 Exam per year
Mammography Screening Facility	Covered in Full	Covered in Full	Covered in Full Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	

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

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

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

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	Covered in Full Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Diabetic Equipment	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	Covered through Rx benefit if purchased through pharmacy.
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	Covered in Full	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Covered in Full for Dependents under 19 Emergency no deductible; Domestic CIF for Emergency and Non Emergency Services. Non emergency for INN/OON 20% after ded

Transportation

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Not Covered	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	Domestic Not Available

Urgent Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full	20% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered Routine Adult Eyewear is not covered. Eyewear is only covered if following Intraocular surgery or Cataract Surgery: Limit once every 24 months. Domestic and INN CIF, OON Deductible/Coinsurance.

Rx Benefits

Rx Plan

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Rx Plan				Custom Rx

Rx Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	100	30		
Days Supply Per Mail Order	N/A	N/A		
Copays Per Mail Order Supply	N/A	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.