Excellus

**BluePoint2**
**$10/$25/$40**
**Benefit Time Period: 01/01/2025 - 12/31/2025**

**Monroe Community College**

# 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 | |
| Coinsurance | 0% | 25% | |
| Annual Out of Pocket Maximum - Single | $6,350 | $6,350 | |
| Annual Out of Pocket Maximum - Family | $12,700 | $12,700 | |

## Office Visit Cost Shares

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cost Share - Primary Care | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Cost Share - Specialist | $20 Copayment | 25% Coinsurance<br>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 | | | No |

## Who is Covered

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Domestic Partner Coverage | | | Covered |

# Inpatient Services

## Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Services | $100 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $100 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | $100 Copayment | 25% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Skilled Nursing Facility | Covered in Full | 25% Coinsurance<br>Subject to Deductible | 45 Days per year |
| Physical Rehabilitation | $100 Copayment | 25% Coinsurance<br>Subject to Deductible | 60 Days per year |
| Maternity Care | $100 Copayment | 25% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |

## Outpatient Facility Services

### Outpatient Facility Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | $50 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Infusion Therapy | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | $20 Copayment | 25% Coinsurance<br>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<br>Subject to $50 Deductible | 40 Visits per year |
| Home Infusion Therapy | Covered in Full | 25% Coinsurance<br>Subject to $50 Deductible | 40 Visits per year |

### Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Hospice Care Inpatient | Covered in Full | 25% Coinsurance<br>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 - $20 Copayment | $20 Copayment | |
| Diagnostic X-ray | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Chemotherapy | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Infusion Therapy | 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/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 | |
| Telehealth | PCP/Specialist - Covered in Full | 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 MDLive Program for medical and behavioral health conditions that are not emergency conditions. |
| Chiropractic Care | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Allergy Testing | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Allergy Treatment Including Serum | PCP/Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Hearing Evaluations Routine | PCP/Specialist - $20 Copayment | Not Covered | Not Covered |

## 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 |
| 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 |
| 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 | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| 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 | |
| Mammography Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | |
| 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 - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - $50 Copayment | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - $20 Copayment | 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 | |
| Colonoscopy Screening Facility | $50 Copayment | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | $20 Copayment | 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<br>Subject to Deductible | |
| Treatment of Diabetes - Insulin | PCP/Specialist - $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diabetic Equipment | PCP/Specialist - $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance | 50% Coinsurance<br>Subject to Deductible | |
| Medical Supplies | PCP/Specialist - 20% Coinsurance | 50% Coinsurance<br>Subject to Deductible | |
| Acupuncture | PCP/Specialist - 50% Coinsurance | 50% Coinsurance<br>Subject to Deductible | 10 Visits Per Contract Year<br>OON: Deductible, then 50% Coinsurance |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

### Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | 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 | $100 Copayment | $100 Copayment | |

### 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<br>Subject to Deductible | |

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Pediatric Eye Exams - Routine | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | 1 Exam per calendar year |
| Pediatric Eyewear - Routine | 20% Coinsurance | 50% Coinsurance<br>Subject to Deductible | 1 Pair per year |
| Adult Eye Exams - Routine | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | 1 Exam every 2 years |
| Adult Eyewear - Routine | Covered | Covered<br>Subject to Deductible | $60 Allowance per year |

## Rx Benefits

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Rx Plan | | | $10/$25/$40 |

## Rx Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Days Supply Per Retail Order | 30 | | |
| Days Supply Per Mail Order | 90 | | |
| Copays Per Mail Order Supply | 2 | | |

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.