Excellus

BluePoint2
$5/$20/$35
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	$300	
Deductible - Family	$0	$750	
Coinsurance	0%	20%	
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	$15 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$15 Copayment	20% 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			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	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	45 Days Per Plan Year
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	20% Coinsurance 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	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance 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	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	$15 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance 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	20% Coinsurance Subject to Deductible	
Mental Health Care	$15 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$15 Copayment	20% 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	20% Coinsurance Subject to $50 Deductible	40 Visits Per Plan Year
Home Infusion Therapy	Covered in Full	20% Coinsurance 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	20% 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 - $15 Copayment	$15 Copayment	
Diagnostic X-ray	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $15 Copayment	20% 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	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - Covered in Full	20% 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 - $15 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP/Specialist - $15 Copayment	Not Covered Subject to Deductible	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$15 Copayment	20% Coinsurance Subject to Deductible	45 Visits Per year.
Occupational Rehabilitation	$15 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$15 Copayment	20% 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 - $15 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $15 Copayment	20% 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 Subject to $1,300 Deductible	1 Exam Per Plan Year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to $1,300 Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% 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	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% 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	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $15 Copayment	20% 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	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$15 Copayment	20% 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 - $15 Copayment	20% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	50% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits Per Contract Year 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	$75 Copayment	$75 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	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$15 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Calendar Year
Pediatric Eyewear - Routine	20% Coinsurance	50% Coinsurance Subject to Deductible	1 Pair Per Calendar Year
Adult Eye Exams - Routine	$15 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per 2 Plan Years
Adult Eyewear - Routine	Covered	Covered Subject to Deductible	$60 Allowance per year

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$20/$35

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.