Excellus

Excellus BluePPO

Drug Coverage Provided by OptumRx
Benefit Time Period: 01/01/2025 - 12/31/2025

COLGATE UNIVERSITY

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$750	
Deductible - Family	$0	$2,250	Each individual does not exceed the single deductible.
Coinsurance	20%	30%	
Annual Out of Pocket Maximum - Single	$1,750 Medical $2,000 Pharmacy	$1,925 Medical N/A Pharmacy	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$3,500 Medical $4,000 Pharmacy	$5,600 Medical N/A Pharmacy	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance	30% 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	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	20% Coinsurance	30% Coinsurance Subject to Deductible	Maternity Inpatient INN: 20% with $750 max cap. Maternity Office Visits and diagnostic testing will be CIF.

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Radiation Therapy	20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance	30% 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	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Care	20% Coinsurance	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	20% Coinsurance	25% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	30% 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity radiological services are CIF.
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	INN: Maternity lab and pathology services are CIF.
Radiation Therapy	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance	30% 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 - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Maternity Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	NYS Maternal Depression Screening Mandate Applies.
Telehealth	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $0 Copayment	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% Coinsurance	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for 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	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	Travel vaccinations covered for Polio, Rabies, Encephalitis, Typhoid, malaria, Hep A&B and Yellow Fever covered in full in and out-of-network.
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	30% 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	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% 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	30% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	Applies to Diagnostic Services.
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance	30% 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	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	20% Coinsurance	30% Coinsurance Subject to Deductible	Applies to Diagnostic Services.
Bone Density Screening Facility	20% Coinsurance	30% 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	30% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a retail pharmacy. Covered through Carve-out Rx vendor or Diabetic DME vendor
Treatment of Diabetes - Insulin	PCP/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a retail pharmacy. Covered through Carve-out Rx vendor or Diabetic DME vendor
Diabetic Equipment	PCP/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	No coverage for insulin and supplies through a retail pharmacy. Covered through Carve-out Rx vendor or Diabetic DME vendor
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	30% 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	20% Coinsurance	20% Coinsurance	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance	20% Coinsurance	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance	30% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$40 Copayment	30% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$40 Copayment	30% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
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	Retail $10/$40/$60 Mail Order $20/$80/$120	Not Covered	Coverage provided by OptumRx

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30	Not Covered	Coverage provided by OptumRx
Days Supply Per Mail Order	90	Not Covered	Coverage provided by OptumRx
Copays Per Mail Order Supply	N/A	Not Covered	Coverage provided by OptumRx

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.