Excellus

Iron Workers District Council of WNY Welfare Fund

Excellus BluePPO
Benefits Effective January 1, 2017

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Calendar Year Deductible - Single	$400	$800	
Calendar Year Deductible - Family	$800	$1,600	Each individual does not exceed the single deductible.
Coinsurance	20%	40%	
Calendar Year Annual Out of Pocket Maximum - Single	$3,000	No limit	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Calendar Year Annual Out of Pocket Maximum - Family	$6,000	No limit	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 Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance
Mental Health Care	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance
Substance Use Detoxification	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance
Skilled Nursing Facility	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance. Limited to 60 days per year, combined in and out of network
Physical Rehabilitation	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance. Limited to 60 days per year, combined in and out of network
Maternity Care	$100 Copayment Subject to Deductible	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance

Benefit Name	In Network	Out of Network	Limits and Additional Information
Routine Newborn Nursery Care	Covered in Full	$200 Copayment and 30% Coinsurance Subject to Deductible	Deductible applies before copayment and coinsurance
Observation Stay	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to In-Network Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a prior authorization.
In-Hospital Physician Visits and Consultations	20% Coinsurance Subject to Deductible	40% 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 Subject to Deductible	30% Coinsurance Subject to Deductible	
Colonoscopy Facility Diagnostic	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Preadmission Pre-Operative Testing	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Routine X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Covered under Home Care Benefit	Covered under Home Care Benefit	Included in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Abuse Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Cardiac Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	Limited to 40 visits per year, combined in and out of network

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care (Inpatient and Outpatient)	Covered in Full Subject to Deductible	30% Coinsurance Subject to Deductible	Limited to 180 days per year, combined in and out of network and combined inpatient and outpatient.

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Colonoscopy Professional Diagnostic	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Routine X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Advanced Imaging Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Professional Diagnostic	Covered in Full	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Covered under Home Care Benefit	Covered under Home Care Benefit	Included in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Abuse Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cardiac Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Office Visits - Diagnostic	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties are included. Office visits may include house calls.
Chiropractic Care	50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	Maximum benefit of $550 per person, combined in and out of network
Allergy Testing	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluation Routine	Covered in Full	Covered in Full	Maximum benefit of $1,000 per person every 3 years towards the cost of hearing aids and exam, combined in and out of network.
Hearing Aids	Covered in Full	Covered in Full	Maximum benefit of $1,000 per person every 3 years towards the cost of hearing aids and exam, combined in and out of network.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	Covered in Full	30% Coinsurance Subject to Deductible	Subject to age and frequency limits
Routine GYN Visit	Covered in Full	30% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pre/Post-Natal Care	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	Covered in Full	40% 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 Professional Services in addition to those required under Federal Guidelines

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services in addition to those required under Federal Guidelines

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	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Non-durable diabetic supplies and insulin covered under Pharmacy Benefit administered by Express Scripts
Durable Medical Equipment (DME)	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Antiembolism and vascular support garments (e.g., Jobst) limited to two (2) per year.
Medical Supplies	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Orthotics	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Orthotics (except for feet) subject to $3,000 maximum per claim
Foot Orthotics	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to $1,000 annual maximum for all foot orthotics
Reproductive and Fertility Services	Not Covered	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered
Private Duty Nursing	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	Covered in Full Subject to Deductible	Covered in Full Subject to In-Network Deductible	Emergency services are covered worldwide if provided by a hospital facility.

ER Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to In-Network Deductible	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	Covered in Full Subject to Deductible	Covered in Full Subject to In-Network Deductible	Non-emergency transportation services are not covered.

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full Subject to Deductible	Covered in Full Subject to In-Network Deductible	

Urgent Care Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physician Urgent Care Center Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to In-Network Deductible	
Physician Office Visit for Urgent Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to In-Network Deductible	

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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.