Service Employees Benefit Fund (SEBF)
2019 Benefit Year

Excellus BluePPO Benefits

Type of Care/Plan Benefits	In-Network	Out-Of-Network
BluePPO Plan Features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Pre-Certification	Required for all inpatient admissions (excluding maternity). Includes Home Health Care, Infusion Therapy, Durable Medical Equipment over $200, MRI, CAT Scans and PET Scans	
Pre-Certification Penalty	No Penalty for In-Network Providers	$400 Penalty, Per Occurance
Out of network benefits	Covered, unless noted. Please note: The amount the plan pays for covered services is based on an allowed amount. If an out of network provider charges more than the allowed amount, you will have to pay the difference between the actual charge and the allowed amount.	
Out of area benefits	Coverage provided worldwide through the BlueCard® program	
Dependent coverage	Qualified dependents covered to age 26 (end of month)	
Domestic partner	Covered (if eligible)	
Coverage Period	January 1st - December 31st	
Plan cost-sharing highlights		
Telemedicine visit with MDLIVE	**FREE VISIT** Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Office visit copay (Primary Care Physician)	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Office visit copay (Specialist)	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Coinsurance	0%, unless noted	30% of allowance, unless noted
Deductible	None	$1,000 Individual $2,000 Family
Out of pocket maximum	$5,150 Individual $7,900 Family	None
Inpatient Hospital/Facility Copayment	$500 Per Admission Limit: $1,500 maximum copayment, per individual, per person, per calendar year	Covered at 70% of allowance, subject to the deductible. Precertification applies
Lifetime maximum	None	
Wellness Incentives		
Stay healthy with great programs and incentives!	**Blue365** - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids. For additional information on **Blue365**, please visit: **www.excellusbcbs.com/sebf**	

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Preventive Health Care Services*		
Well child visits	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult routine physical exam	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult immunizations	Covered in Full	Covered at 100% of allowance, subject to the deductible
Mammography	Covered in Full	Covered at 70% of allowance, subject to the deductible
Pap smear	Covered in Full	Covered at 70% of allowance, subject to the deductible
Routine GYN exam	Covered in Full	Covered at 70% of allowance, subject to the deductible
Prostate cancer screening	Covered in Full	Covered at 70% of allowance, subject to the deductible
Colonoscopy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Physician Office Services		
Telemedicine visit with MDLIVE	**FREE VISIT** Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Diagnostic office visits	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Surgery	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	$75 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible
Allergy testing	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Allergy treatment including serum	Covered in Full	Covered at 70% of allowance, subject to the deductible

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Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Infusion therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Maternity Services		
Prenatal Care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Hospital care for mom (including delivery)	$500 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Newborn nursery care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient Hospital Benefits		
Hospital benefits	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Physician visits in the hospital	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient physical rehabilitation	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Limit: 60 days per calendar year. Precertification applies
Surgery (Professional charge)	Covered in Full	Covered at 70% of allowance, subject to the deductible
Anesthesia	Covered in Full	Covered at 70% of allowance, subject to the deductible
Emergency Care		
Emergency room care	**No Coverage for Non-Emergency Care** $100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient)	**No Coverage for Non-Emergency Care** $100 Copayment per visit then Covered at 100% of allowance (Copayment waived if admitted inpatient)
Freestanding urgent care center	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Observation stay	$100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient)	Covered at 70% of allowance, subject to the deductible

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Ambulance (Ground or Air)	$50 Copayment then Covered in Full	$50 Copayment then Covered at 100% of allowance
Outpatient Hospital Benefits		
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	$75 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible
Surgical care (Facility Fee: Includes Ambulatory Surgery Center)	$75 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Mental Health and Chemical Dependence		
Inpatient mental health care	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient mental health care	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Inpatient chemical dependence	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient chemical dependence	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Other Services		
Skilled nursing facility	$500 Copayment then Covered in Full. Limit: 60 visits per calendar year. Limits are combined INN and OON. Precertification applies	Covered at 70% of allowance, subject to the deductible. Limit: 60 visits per calendar year. Limit are combined INN and OON. Precertification applies
Home care	$40 Copayment Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies	Covered at 75% of allowance, subject to deductible. Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies
Hospice	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies.

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Infusion Therapy (Facility Charge)	$40 Copayment Precertification applies	Covered at 75% of allowance, subject to the deductible. Precertification applies
Outpatient therapy (Physical and Occupational)	$40 Copayment Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.
Outpatient therapy (Speech)	$40 Copayment Limit: Total of 20 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Total of 20 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.
Cardiac & Pulmonary Rehabilitation	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Diabetic insulin and supplies	Covered only through your Prescription Drug Plan with Express Scripts.	Covered only through your Prescription Drug Plan with Express Scripts.
Durable medical equipment	Covered at 80% Precertification applies if over $200	Covered at 70% of allowance, subject to the deductible. Precertification applies if over $200
External prosthetics	Covered in Full	Covered at 70% of allowance, subject to the deductible
Chiropractic	$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Acupuncture	$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Infertility Services	Covered same as similar services under the benefit plan. Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined
Routine Hearing Exam	$40 Copayment Limit: 1 exam every 24 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible. Limit: 1 exam every 24 months. INN & OON limits are combined
Hearing Aids	$40 Copayment Limit: $2,500 maximum per 12 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible. Limit: $2,500 maximum per 12 months. INN & OON limits are combined

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Accidental Dental	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.	Covered at 70% of allowance, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.
Quit for Life Tobacco Program	**<u>This FREE Program includes:</u> - One-on-one counseling with a Professional Quit Coach. - Medication recommendations, if appropiate. - Free nicotine replacement products (patch or gum) if recommended. Call 1-800-442-8904 for more information. Quit Coaches are available 24 hours a day. 18 years or older**	
Smoking Cessation (Quit Smoking)	**<u>Administered through SEBF</u> No deductible - 100% reimbursement $500 lifetime maximum per person Contact SEBF for more details: 315-218-6513**	
Prescription Drug Coverage	**<u>Administered through Express Scripts</u> www.express-scripts.com 1-866-544-2926**	
Excellus BlueCross BlueShield Customer Care: 1-877-650-5840 www.excellusbcbs.com/sebf		

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. These benefits should not be interpreted as pre-approval of services. Payment of claims related to these benefits are subject to the member's eligibility on the date of service and the resolution of any other outstanding claims. The member is responsible for payment of a copay, deductible, coinsurance or any combination based on plan design.

*Preventive Services are not subject to Cost-Sharing when performed by a Participating Provider and provided in accordance with the comprehensive guidelines (including age and visit guidelines) supported by the Health Resources and Services Administration (HSRA) or if the items or services have a "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP).