Excellus

# Finger Lakes Area School Health Plan

## Benefit Comparison
## Benefit Time Period 07/01/2023 - 06/30/2024

## Cost Sharing Expenses

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Deductible - Single | $0 | $300 | | $0 | $500 | |
| Deductible - Family | $0 | $750 | | $0 | $1,250 | |
| Coinsurance | 0% | 25% | | 0% | 25% | |
| Annual Out of Pocket Maximum - Single | $6,350 | $6,350 | | $6,350 | $6,350 | |
| Annual Out of Pocket Maximum - Family | $12,700 | $12,700 | | $12,700 | $12,700 | |

## Office Visit Cost Shares

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Cost Share - Primary Care | $15 Copayment | 25% Coinsurance Subject to Deductible | | $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Cost Share - Specialist | $15 Copayment | 25% Coinsurance Subject to Deductible | | $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Cost Share - Sick Kids | $5 Copayment | 25% Coinsurance Subject to Deductible | | $20 Copayment | 25% Coinsurance Subject to Deductible | |

## Plan Limits

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Plan/Calendar Year | | | Calendar Year Benefits | | | Calendar Year Benefits |
| Diabetic Preauthorization and Step Therapy | | | No | | | No |

| | BluePoint2 $15 | | | BluePoint2 $20 | | |
|---|---|---|---|---|---|---|
| **Who is Covered** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Domestic Partner Coverage | | | Covered | | | Covered |
| **Inpatient Facility** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Inpatient Hospital Services | Covered in Full | 25% Coinsurance Subject to Deductible | | $100 Copayment | 25% Coinsurance Subject to Deductible | |
| Mental Health Care | Covered in Full | 25% Coinsurance Subject to Deductible | | $100 Copayment | 25% Coinsurance Subject to Deductible | |
| Substance Use Detoxification | Covered in Full | 25% Coinsurance Subject to Deductible | | $100 Copayment | 25% Coinsurance Subject to Deductible | |
| Skilled Nursing Facility | Covered in Full | 25% Coinsurance Subject to Deductible | 120 Days Per Year | Covered in Full | 25% Coinsurance Subject to Deductible | 45 Days Per Year |
| Physical Rehabilitation | Covered in Full | 25% Coinsurance Subject to Deductible | 60 Days per year | $100 Copayment | 25% Coinsurance Subject to Deductible | 60 Days Per Calendar Year |
| Maternity Care | Covered in Full | 25% Coinsurance Subject to Deductible | | $100 Copayment | 25% Coinsurance Subject to Deductible | |
| **Inpatient Professional Services** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Inpatient Hospital Surgery | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Anesthesia | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| **Outpatient Facility Services** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | Covered in Full | 25% Coinsurance Subject to Deductible | | $50 Copayment | 25% Coinsurance Subject to Deductible | |
| Diagnostic X-ray | $15 Copayment | 25% Coinsurance Subject to Deductible | | $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 25% Coinsurance Subject to Deductible | | Covered in Full | 25% Coinsurance Subject to Deductible | |

| | BluePoint2 $15 | | | BluePoint2 $20 | | |
|---|---|---|---|---|---|---|
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Radiation Therapy | Covered in Full | 25% Coinsurance<br>Subject to Deductible | | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | $15 Copayment | 25% Coinsurance<br>Subject to Deductible | | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Infusion Therapy | Inclusive to Primary Service | Inclusive to Primary Service | | Inclusive of Primary Service | Inclusive of Primary Service | |
| Dialysis | Covered in Full | 25% Coinsurance<br>Subject to Deductible | | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $15 Copayment | 25% Coinsurance<br>Subject to Deductible | | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Substance Use Care | $15 Copayment | 25% Coinsurance<br>Subject to Deductible | | $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |

## Home Care

| Benefit Name | In Network | Out of Network | Limits | In Network | Out of Network | Limits |
|---|---|---|---|---|---|---|
| Home Care | Covered in Full | 25% Coinsurance<br>Subject to $50<br>Deductible | | Covered in Full | 25% Coinsurance<br>Subject to $50<br>Deductible | |
| Home Infusion Therapy | Covered in Full | 25% Coinsurance<br>Subject to $50<br>Deductible | | Covered in Full | 25% Coinsurance<br>Subject to $50<br>Deductible | |

## Hospice Care

| Benefit Name | In Network | Out of Network | Limits | In Network | Out of Network | Limits |
|---|---|---|---|---|---|---|
| Hospice Care Inpatient | Covered in Full | 25% Coinsurance<br>Subject to Deductible | | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |

## Professional Services

| Benefit Name | In Network | Out of Network | Limits | In Network | Out of Network | Limits |
|---|---|---|---|---|---|---|
| Office Surgery | PCP / Specialist - $15 Copayment | 25% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP / Specialist - $15 Copayment | 25% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP / Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |

| | BluePoint2 $15 | | | BluePoint2 $20 | | |
|---|---|---|---|---|---|---|
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Radiation Therapy | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Chemotherapy | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Infusion Therapy | PCP / Specialist - Inclusive of Primary Service | Inclusive of Primary Service | | PCP / Specialist - Inclusive of Primary Service | Inclusive of Primary Service | |
| Dialysis | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Mental Health Care | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Maternity Care | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Telehealth | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| TeleMedicine Program | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |
| Chiropractic Care | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Allergy Testing | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Allergy Treatment Including Serum | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Hearing Evaluations Routine | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | 1 Exam per year | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | 1 Exam per year |

## Outpatient Facility

| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
|---|---|---|---|---|---|---|
| Physical Rehabilitation | $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |
| Occupational Rehabilitation | $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |
| Speech Rehabilitation | $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |

| | BluePoint2 $15 | | | BluePoint2 $20 | | |
|---|---|---|---|---|---|---|
| **Outpatient Professional Services** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Physical Rehabilitation | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |
| Occupational Rehabilitation | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |
| Speech Rehabilitation | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits per calendar year | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | 30 Visits Per Calendar Year |
| **Preventive Professional Services Meeting Federal Guidelines*** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Adult Physical Examination | PCP / Specialist - Covered in Full | Not Covered | 1 Exam per calendar year | PCP / Specialist - Covered in Full | Not Covered | 1 Exam per year |
| Adult Immunizations | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |
| Well Child Visits and Immunizations | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Routine GYN Visit | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | 2 Exam per year | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | 2 exam per calendar year |
| Pre/Post-Natal Care | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |

| | BluePoint2 $15 | | | BluePoint2 $20 | | |
|---|---|---|---|---|---|---|
| **Preventive Facility Services Meeting Federal Guidelines*** | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Cervical Cytology Preventative | Covered in Full | 25% Coinsurance Subject to Deductible | 2 per year | Covered in Full | 25% Coinsurance Subject to Deductible | 2 per calendar year |
| Mammography Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | | Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | | Covered in Full | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | | 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** | **In Network** | **Out of Network** | **Limits** |
| Prostate Cancer Screening | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | 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** | **In Network** | **Out of Network** | **Limits** |
| Mammography Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | | Covered in Full | 25% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 25% Coinsurance Subject to Deductible | | $50 Copayment | 25% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | $15 Copayment | 25% Coinsurance Subject to Deductible | | $20 Copayment | 25% Coinsurance Subject to Deductible | |

## Additional Benefits

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Treatment of Diabetes Insulin and Supplies | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Diabetic Equipment | PCP / Specialist - $15 Copayment | 25% Coinsurance Subject to Deductible | | PCP / Specialist - $20 Copayment | 25% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP / Specialist - 20% Coinsurance | 25% Coinsurance Subject to Deductible | | PCP / Specialist - 20% Coinsurance | 50% Coinsurance Subject to Deductible | |
| Medical Supplies | PCP / Specialist - Not Covered | Not Covered | | PCP / Specialist - Not Covered | Not Covered | Not Covered |
| Acupuncture | PCP / Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits per calendar year | PCP / Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits Per Calendar Year |
| Private Duty Nursing | PCP / Specialist - Not Covered | Not Covered | Not Covered | PCP / Specialist - Not Covered | Not Covered | Not Covered |

## Diagnoses

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Reimbursement for Travel and Lodging Expenses | PCP / Specialist - Covered | Covered | $4,000 Reimbursement Per Plan Year | PCP / Specialist - Covered | Covered | $4,000 Reimbursement Per Plan Year |

## ER Facility

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Facility Emergency Room Visit | $50 Copayment | $50 Copayment | | $50 Copayment | $50 Copayment | |

## Transportation

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Prehospital Emergency and Transportation - Ground or Water | $25 Copayment | $25 Copayment | | $25 Copayment | $25 Copayment | |

## Urgent Care

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Urgent Care Center Facility Visit | $25 Copayment | 25% Coinsurance Subject to Deductible | | $25 Copayment | 25% Coinsurance Subject to 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.

## Vision

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Pediatric Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exam per calendar year | $20 Copayment | Not Covered | 1 Exam per calendar year |
| Pediatric Eyewear - Routine | 20% Coinsurance | Not Covered | 1 Pair per calendar year | 20% Coinsurance | Not Covered | 1 Pair per calendar year |
| Adult Eye Exams - Routine | $15 Copayment | Not Covered | 1 Exam every 2 calendar years | $20 Copayment | Not Covered | 1 Exam every 2 calendar years |
| Adult Eyewear - Routine | Covered | Not Covered | $60 Reimbursement every 2 calendar years | Covered | Not Covered | $60 Reimbursement every 2 calendar years |

## Rx Plan

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Rx Plan | | | $0/$30/$50 | | | $0/$30/$50 |

## Rx Benefits

| Benefit Name | BluePoint2 $15 In Network | BluePoint2 $15 Out of Network | BluePoint2 $15 Limits | BluePoint2 $20 In Network | BluePoint2 $20 Out of Network | BluePoint2 $20 Limits |
|---|---|---|---|---|---|---|
| Days Supply Per Retail Order | 90 | | | 90 | | |
| Days Supply Per Mail Order | 90 | | | 90 | | |
| Copays Per Mail Order Supply | 2 | | | 2 | | |

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