

Finger Lakes Area School Health Plan

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$300	
Deductible - Family	\$0	\$750	
Deductible Aggregation - Single and Family			Each family member is only subjected to the single Deductible and any combination of family members can satisfy the family deductible as long as on individual does not meet more than the single deductible. Individual
Coinsurance	0%	25%	
Annual Out of Pocket Maximum - Single	\$6,350	\$6,350	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	\$12,700	\$12,700	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 Aggregation - Single and Family			Each family member is only subjected to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$15 Copayment	25% Coinsurance Subject to Deductible	\$5 PCP OV and Treatment for sick children up to age 19
Cost Share - Specialist	\$15 Copayment	25% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	\$5 Copayment	25% Coinsurance Subject to Deductible	\$5 PCP OV and Treatment for sick children up to age 19

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	25% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	25% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	25% Coinsurance Subject to Deductible	120 Days Per Year 360 days per lifetime.
Physical Rehabilitation	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	25% 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	25% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	25% 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	25% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$15 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	25% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	\$15 Copayment	25% Coinsurance Subject to Deductible	\$15 copay for IV / inject-able chemotherapy in addition to a \$15 copay for the office visit. 2 copay max per day
Infusion Therapy Outpatient	Inclusive to Primary Service	Inclusive to Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit
Dialysis	Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	\$15 Copayment	25% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	\$15 Copayment	25% 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	25% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	Covered in Full	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	25% 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	25% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	\$15 copay for IV / inject-able chemotherapy in addition to a \$15 copay for the office visit. 2 copay max per day
Infusion Therapy Services	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	25% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - \$15 Copayment	25% 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 and, if applicable, Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	\$5 PCP OV and treatment for sick children up to age 19
Allergy Treatment Including Serum	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	\$5 PCP OV and treatment for sick children up to age 19
Hearing Evaluations Routine	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	\$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. 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 - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year Limit 30 visits per calendar year combined in and out-of-network. 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	Not Covered	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	HCR services covered in full
Well Child Visits and Immunizations	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
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	25% 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	25% Coinsurance Subject to Deductible	2 per year when done in conjunction with routine GYN exam
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	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 and Additional Information
Prostate Cancer Screening	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - \$15 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 and Additional Information
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$15 Copayment	25% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - \$0 Copayment	25% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - \$15 Copayment	25% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Not Covered	Not Covered	
Acupuncture	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

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered	Covered	\$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides.

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	\$50 Copayment	\$50 Copayment	

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	\$25 Copayment	\$25 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	\$25 Copayment	25% Coinsurance Subject to Deductible	

Total Health Management Programs

Wellness Programs

Benefit Name	In Network	Out of Network	Limits and Additional Information
Wellbeing Program			A wellbeing program that encourages members to take a more active role in managing their health and wellness. Members can participate in and complete a certified health risk assessment, various wellness and gamification-style activities, including challenges, health journeys, daily cards, healthy habit tracking and more that motivates them to focus on their total health and wellbeing. ThriveWell

Ancillary Benefits

Vision

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

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			\$0/\$30/\$50

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	90		
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.