Excellus

**BluePoint2**
**$0/$30/$50**
**Benefit Time Period: 07/01/2025 - 06/30/2026**

**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 satisy the family deductible as long as on individual does not meet more than the single deductible.<br>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.<br>Individual |

## Office Visit Cost Shares

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cost Share - Primary Care | $5 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Cost Share - Specialist | $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Cost Share - Sick Kids | $5 PCP/ $10 Specialist Copayment | 25% Coinsurance<br>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 | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | Covered in Full | 25% Coinsurance<br>Subject to Deductible | 120 Days Per Year<br>360 days per lifetime |
| Physical Rehabilitation | Covered in Full | 25% Coinsurance<br>Subject to Deductible | 60 Days per year |
| Maternity Care | Covered in Full | 25% Coinsurance<br>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<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - Covered in Full | 25% Coinsurance<br>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<br>Subject to Deductible | |
| Diagnostic X-ray | $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | $5 PCP / $10 Specialist Copayment | 25% Coinsurance<br>Subject to Deductible | Copay on the drug in addition to PCP/Specialist visit copay - 2 copay per day |
| Infusion Therapy Outpatient | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis | Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | $5 Copayment | 25% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | $5 Copayment | 25% Coinsurance<br>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<br>Subject to $50 Deductible | |
| Home Infusion Therapy | Covered in Full | 25% Coinsurance<br>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<br>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 - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP - $5 Copayment<br>Specialist - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | Copay on the drug in addition to PCP/Specialist visit copay - 2 copay 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<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - $5 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - Covered in Full | 25% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP - $5 Copayment<br>Specialist - $10 Copayment | 25% Coinsurance<br>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 - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Allergy Testing | PCP - $5 Copayment<br>Specialist - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Allergy Treatment Including Serum | PCP - $5 Copayment<br>Specialist - $10 Copayment | 25% Coinsurance<br>Subject to Deductible | |
| Hearing Evaluations Routine | PCP/Specialist - $10 Copayment | 25% Coinsurance<br>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 | $10 Copayment | 25% Coinsurance<br>Subject to Deductible | 30 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | $10 Copayment | 25% Coinsurance<br>Subject to Deductible | 30 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | $10 Copayment | 25% Coinsurance<br>Subject to Deductible | 30 Visits per year<br>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 - $10 Copayment | 25% Coinsurance Subject to Deductible | 30 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 - $10 Copayment | 25% Coinsurance Subject to Deductible | 30 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 - $10 Copayment | 25% Coinsurance Subject to Deductible | 30 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 | Not Covered | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| 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 - $5 Copayment Specialist - $10 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 - $10 Copayment | 25% Coinsurance Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Bone Density Screening Professional | PCP/Specialist - $10 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 | $10 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 - $5 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 - $5 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 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<br>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.<br>ThriveWell |

## Ancillary Benefits

### Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Pediatric Eye Exams - Routine | $10 Copayment | Not Covered | 1 Exam per calendar year |
| Pediatric Eyewear - Routine | 20% Coinsurance | 25% Coinsurance<br>Subject to Deductible | 1 Pair per calendar year<br>Limits are combined in and out of network |
| Adult Eye Exams - Routine | $10 Copayment | Not Covered | 1 Exam every 2 calendar years |
| Adult Eyewear - Routine | Covered | 25% Coinsurance<br>Subject to Deductible | $60 Reimbursement every 2 calendar years for INN; OON is covered at Ded/Coins 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.