Excellus

Healthy Blue Copay
$5/$25/$50, $0 Gen for Kids
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	$500	
Deductible - Family	$0	$1,500	Each individual does not exceed the single deductible.
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 one individual does not meet more than the single deductible. Individual
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	$4,200	$4,620	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	$12,600	$13,860	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	$25 Copayment	20% Coinsurance Subject to Deductible	$0 copayment for dependents to age 19 on all In-Network PCP office visits.
Cost Share - Specialist	$40 Copayment	20% Coinsurance 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			Yes

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	$250 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$250 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$250 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$250 Copayment	20% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	$250 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	20% 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	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$150 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$40 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$40 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$25 Copayment	20% Coinsurance Subject to Deductible	IV/injectable chemo will apply the copay on the drug in addition to an OV copay. Maximum 2 copays per provider per day - 1 for OV, 1 for injectable. Kids apply the same dollar copay as adults.
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	20% Coinsurance Subject to Deductible	Injectable copay applies
Mental Health Care	$25 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$25 Copayment $0 PCP Copay for members to age 19.	20% 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	20% Coinsurance Subject to $50 Deductible	40 Visits per year Limits are combined INN and OON.
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% 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 - $25 Copayment Specialist - $40 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	IV/injectable drug will apply additional copay. Maximum of 2 copays per provider per day: One copay for visit and one copay for IV/injectable drug. Kids apply the same dollar copay as adults.
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	20% Coinsurance Subject to Deductible	Injectable copay applies
Mental Health Care	PCP/Specialist - $25 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	$0 Kids Copay applies to PCP and Specialist
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP - $25 Copayment Specialist - $40 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full $0 PCP Copay for members to age 19.	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 - $40 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP - $25 Copayment Specialist - $40 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP - $25 Copayment Specialist - $40 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$40 Copayment	20% Coinsurance Subject to Deductible	45 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	$40 Copayment	20% Coinsurance Subject to Deductible	45 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	$40 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year 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 - $40 Copayment	20% Coinsurance Subject to Deductible	45 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 - $40 Copayment	20% Coinsurance Subject to Deductible	45 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 - $40 Copayment	20% Coinsurance Subject to Deductible	45 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	20% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes Flu Shots & pneumonia vaccine. Flu mist covered according to Medical Policies. Physician administered inject-able copay does not apply.
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% 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	20% Coinsurance Subject to Deductible	Pap Smear and pelvic exam does not include breast exam.
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% 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 - Covered in Full	20% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $40 Copayment	20% 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	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$40 Copayment	20% 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 - $25 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Pre-authorization / Step Therapy applies.
Treatment of Diabetes - Insulin	PCP/Specialist - $0 Copayment	20% 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 - $25 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - $40 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year Limits combined INN and OON.
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	$150 Copayment	$150 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. Waived if admitted as IP (IP copay applies). Waived for Observation Stay (Observation Stay copay applies).

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$150 Copayment	$150 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$40 Copayment	20% Coinsurance Subject to Deductible	

Total Health Management Programs

Wellness Programs

Benefit Name	In Network	Out of Network	Limits and Additional Information
Wellbeing Program			Members can earn up to $500 per plan year in rewards that can be used to purchase gift cards, fitness tracking devices or various other health and wellness items. Rewards are earned by completing gamification-style activities, including health challenges and journeys, daily cards, healthy habit tracking, and $25 can be earned for completing a Health Risk Assessment that motivates them to focus on their total health and wellbeing. ThriveWell Rewards
Reward Amount			Rewards 1 $500 EE & Spouse w/ $25 HRA

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$40 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Pediatric Eyewear - Routine	20% Coinsurance	20% Coinsurance Subject to Deductible	1 Pair Per year Limits are combined in and out of network
Adult Eye Exams - Routine	$40 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	$60 Reimbursement per year $60 reimbursement on hardware per member per year, combined in and out of network

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$25/$50, $0 Gen for Kids

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
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.