Excellus

ROCHESTER CITY SCHOOL DISTRICT

Benefit Comparison
Benefit Time Period 01/01/2027 - 12/31/2027

General Information

Cost Sharing Expenses

Benefit Name	SimplyBlue Copay In Network	SimplyBlue Copay Out of Network	SimplyBlue Copay Limits	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Deductible - Single	$600	$5,000		$0	Not Covered		$250	Not Covered	
Deductible - Family	$1,200	$10,000		$0	Not Covered		$750	Not Covered	
Coinsurance	0%	40%		0%	Not Covered		20%	Not Covered	
Annual Out of Pocket Maximum - Single	$4,000	$10,000		$6,350	Not Covered		$6,350	Not Covered	
Annual Out of Pocket Maximum - Family	$8,000	$20,000		$12,700	Not Covered		$12,700	Not Covered	

Office Visit Cost Shares

Benefit Name	SimplyBlue Copay In Network	SimplyBlue Copay Out of Network	SimplyBlue Copay Limits	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Cost Share - Primary Care	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		$20 Copayment	Not Covered	
Cost Share - Specialist	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		$40 Copayment	Not Covered	
Cost Share - Sick Kids	$0 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$0 Copayment	Not Covered		N/A	Not Covered	

Plan Limits

Benefit Name	SimplyBlue Copay In Network	SimplyBlue Copay Out of Network	SimplyBlue Copay Limits	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			No			No

Who is Covered

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Domestic Partner Coverage			Not Covered			Not Covered			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Substance Use Detoxification	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Skilled Nursing Facility	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	$200 Days per year	Covered in Full	Not Covered	120 Days per year	20% Coinsurance Subject to Deductible	Not Covered	120 Days per year
Physical Rehabilitation	$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	Not Covered	60 Days per year	20% Coinsurance Subject to Deductible	Not Covered	60 Days per year
Maternity Care	$1,000 Copayment	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - $1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Anesthesia	PCP / Specialist - Covered in Full Subject to Deductible	Covered in Full Subject to $600 Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$100 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Diagnostic X-ray	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		$40 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		$20 Copayment	Not Covered	
Radiation Therapy	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		$40 Copayment	Not Covered	
Chemotherapy	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		$40 Copayment	Not Covered	
Chemotherapy Medications									
Infusion Therapy Outpatient	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible		Inclusive of Primary Services	Not Covered		Inclusive of Primary Service	Not Covered	
Dialysis	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		$40 Copayment	Not Covered	
Substance Use Care	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$15 Copayment	Not Covered		$40 Copayment	Not Covered	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		$20 Copayment	Not Covered	40 Visits per year
Home Infusion Therapy	$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Home Dialysis	0% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	120 Visits per year	Covered in Full	Not Covered		20% Coinsurance Subject to $50 Deductible	Not Covered	

Hospice Care

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Hospice Care Inpatient	0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - $100 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Radiation Therapy	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Chemotherapy	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Infusion Therapy Services	PCP / Specialist - Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Services	Not Covered		PCP / Specialist - Inclusive of Primary Service	Not Covered	
Dialysis	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	PCP / Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Maternity Care	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Telehealth	Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		Specialist - $40 Copayment PCP - $20 Copayment	Not Covered	
TeleMedicine Program	PCP / Specialist - $5 Copayment Subject to Deductible	Not Covered		PCP / Specialist - $5 Copayment $0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - $5 Copayment	Not Covered	
Chiropractic Care	Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Allergy Testing	Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment $0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - $20 Copayment $0 PCP Copay for members to age 19.	Not Covered	
Allergy Treatment Including Serum	Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment $0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - $20 Copayment $0 PCP Copay for members to age 19.	Not Covered	
Hearing Evaluations Routine	Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment	40% Coinsurance Subject to $5000 Deductible	1 Exam Per Year	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year
Occupational Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year
Speech Rehabilitation	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per year
Speech Rehabilitation	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Adult Immunizations	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Routine GYN Visit	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	1 Exam per year	Covered in Full	Not Covered	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	

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	In Network	Out of Network	Limits
Prostate Cancer Screening	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		Specialist - $40 Copayment PCP - $20 Copayment	Not Covered	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP / Specialist - $40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	

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	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Bone Density Screening Facility	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Treatment of Diabetes - Insulin	PCP / Specialist - $25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Diabetic Equipment	PCP / Specialist - $25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 50% Coinsurance	Not Covered	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 50% Coinsurance	Not Covered	
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits Per Contract Year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits Per Contract Year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

	SimplyBlue Copay			Enhanced Plan			Core Plan		
Diagnoses									
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Emergency Services									
ER Facility									
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	$150 Copayment Subject to Deductible	$150 Copayment Subject to $600 Deductible		$50 Copayment	$50 Copayment		$50 Copayment	$50 Copayment	
Transportation									
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	$150 Copayment Subject to Deductible	$150 Copayment Subject to $600 Deductible		$15 Copayment	$15 Copayment		$50 Copayment	$50 Copayment	
Urgent Care									
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		$25 Copayment	Not Covered		$25 Copayment	Not Covered	
Ancillary Benefits									
Vision									
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	$15 Copayment	Not Covered	1 Exam per year	$20 Copayment	Not Covered	1 Exam every year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	20% Coinsurance	Not Covered	1 Pair per year	50% Coinsurance	Not Covered	1 Pair every 2 years
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	$15 Copayment	Not Covered	1 Exam per year	$20 Copayment	Not Covered	1 Exam every year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Covered	Not Covered	$100 Reimbursement per year	Covered	Not Covered	$60 Reimbursement every 2 years
Rx Benefits									

Rx Plan

Benefit Name	SimplyBlue Copay In Network	SimplyBlue Copay Out of Network	SimplyBlue Copay Limits	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Rx Plan			$10/$35/$70 EXCHANGE			$5/$20/$35			$10/$30/$50

Rx Benefits

Benefit Name	SimplyBlue Copay In Network	SimplyBlue Copay Out of Network	SimplyBlue Copay Limits	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Days Supply Per Retail Order	90			90			90		
Days Supply Per Mail Order	90			90			90		
Copays Per Mail Order Supply	1			1			1		