Excellus

ROCHESTER CITY SCHOOL DISTRICT

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

Cost Sharing Expenses

Benefit Name	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	$0	Not Covered		$250	Not Covered	
Deductible - Family	$0	Not Covered		$750	Not Covered	
Coinsurance	0%	Not Covered		20%	Not Covered	
Annual Out of Pocket Maximum - Single	$6,350	Not Covered		$6,350	Not Covered	
Annual Out of Pocket Maximum - Family	$12,700	Not Covered		$12,700	Not Covered	

Office Visit Cost Shares

Benefit Name	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	$15 Copayment	Not Covered		$20 Copayment	Not Covered	
Cost Share - Specialist	$15 Copayment	Not Covered		$40 Copayment	Not Covered	

Plan Limits

Benefit Name	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
Diabetic Preauthorization and Step Therapy			No			No

Who is Covered

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

	Enhanced Plan			Core Plan		
Inpatient Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Services	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Substance Use Detoxification	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Skilled Nursing Facility	Covered in Full	Not Covered	120 Days per year	20% Coinsurance Subject to Deductible	Not Covered	120 Days per year
Physical Rehabilitation	Covered in Full	Not Covered	60 Days per year	20% Coinsurance Subject to Deductible	Not Covered	60 Days per year
Maternity Care	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**
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Anesthesia	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Outpatient Facility Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$15 Copayment	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	$15 Copayment	Not Covered		$40 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	Covered in Full	Not Covered		$20 Copayment	Not Covered	
Radiation Therapy	Covered in Full	Not Covered		$40 Copayment	Not Covered	
Chemotherapy	Covered in Full	Not Covered		$40 Copayment	Not Covered	

	Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Chemotherapy Medications						
Infusion Therapy Outpatient	Inclusive of Primary Services	Not Covered		Inclusive of Primary Service	Not Covered	
Dialysis	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	$15 Copayment	Not Covered		$40 Copayment	Not Covered	
Substance Use Care	$15 Copayment	Not Covered		$40 Copayment	Not Covered	

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	Not Covered		$20 Copayment	Not Covered	40 Visits per year
Home Infusion Therapy	Covered in Full	Not Covered		Covered in Full	Not Covered	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	Not Covered		Covered in Full	Not Covered	

Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Diagnostic X-ray	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Radiation Therapy	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	

	Enhanced Plan			Core Plan		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Chemotherapy	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Infusion Therapy Services	PCP / Specialist - Inclusive of Primary Services	Not Covered		PCP / Specialist - Inclusive of Primary Service	Not Covered	
Dialysis	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Mental Health Care	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $40 Copayment	Not Covered	
Maternity Care	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Telehealth	PCP / Specialist - $15 Copayment	Not Covered		Specialist - $40 Copayment PCP - $20 Copayment	Not Covered	
TeleMedicine Program	PCP / Specialist - $5 Copayment $0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - $5 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Allergy Testing	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	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	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Outpatient Facility

Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year
Occupational Rehabilitation	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year
Speech Rehabilitation	$15 Copayment	Not Covered	45 Visits per year	$40 Copayment	Not Covered	45 Visits per year

	Enhanced Plan			Core Plan		
Outpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per year
Speech Rehabilitation	PCP / Specialist - $15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - $40 Copayment	Not Covered	45 Visits per 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 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	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Routine GYN Visit	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	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Mammography Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	

	Enhanced Plan			Core Plan		
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	Not Covered	1 Exam per year	Covered in Full	Not Covered	
Mammography Screening Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	
Bone Density Screening Facility	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**
Prostate Cancer Screening	PCP / Specialist - $15 Copayment	Not Covered		Specialist - $40 Copayment PCP - $20 Copayment	Not Covered	
Mammography Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Bone Density Screening Professional	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**
Mammography Screening Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	
Colonoscopy Screening Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	
Bone Density Screening Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	

Additional Benefits

Benefit Name	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Treatment of Diabetes - Insulin	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Diabetic Equipment	PCP / Specialist - $15 Copayment	Not Covered		PCP / Specialist - $20 Copayment	Not Covered	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 50% Coinsurance	Not Covered	
Medical Supplies	PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 50% Coinsurance	Not Covered	
Acupuncture	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

Diagnoses

Benefit Name	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

ER Facility

Benefit Name	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Facility Emergency Room Visit	$50 Copayment	$50 Copayment		$50 Copayment	$50 Copayment	

Transportation

Benefit Name	Enhanced Plan In Network	Enhanced Plan Out of Network	Enhanced Plan Limits	Core Plan In Network	Core Plan Out of Network	Core Plan Limits
Prehospital Emergency and Transportation - Ground or Water	$15 Copayment	$15 Copayment		$50 Copayment	$50 Copayment	

	Enhanced Plan			Core Plan		
Urgent Care						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	$25 Copayment	Not Covered		$25 Copayment	Not Covered	
Vision						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Pediatric Eye Exams - Routine	$15 Copayment	Not Covered	1 Exam per year	$20 Copayment	Not Covered	1 Exam every year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per year	50% Coinsurance	Not Covered	1 Pair every 2 years
Adult Eye Exams - Routine	$15 Copayment	Not Covered	1 Exam per year	$20 Copayment	Not Covered	1 Exam every year
Adult Eyewear - Routine	Covered	Not Covered	$100 Reimbursement per year	Covered	Not Covered	$60 Reimbursement every 2 years
Rx Plan						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Rx Plan			$5/$20/$35			$10/$30/$50
Rx Benefits						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Days Supply Per Retail Order	90			90		
Days Supply Per Mail Order	90			90		
Copays Per Mail Order Supply	1			1		