Excellus

# Benefit Comparison
## Benefit Time Period 01/01/2026 - 12/31/2026

## ROCHESTER CITY SCHOOL DISTRICT

## General Information

### Cost Sharing Expenses

| Benefit Name | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO 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 and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO 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 | | | | | | | |

### Plan Limits

| Benefit Name | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO 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 and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan Limits |
|---|---|---|---|---|---|---|---|---|
| | | | | | Not Covered | | | Not Covered |

| Benefit Name | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan Limits |
|---|---|---|---|---|---|---|---|---|---|
| Domestic Partner Coverage | | | Not Covered | Covered in Full | Not Covered | | 20% Coinsurance Subject to Deductible | Not Covered | |

## Inpatient Services

### Inpatient Facility

| Benefit Name | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan 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 | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan 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 | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan 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 | |
| | | | | $15 Copayment | Not Covered | | $40 Copayment | Not Covered | |
| | | | | Covered in Full | Not Covered | | $20 Copayment | Not Covered | |

| | SimplyBlue Copay and Deductible Private Exchange | | | Excellus BlueEPO Enhanced Plan | | | Excellus BlueEPO 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | Covered in Full | Not Covered | | $40 Copayment | Not Covered | |
| Diagnostic Laboratory and Pathology | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | Covered in Full | Not Covered | | $40 Copayment | Not Covered | |
| Radiation Therapy | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | | | | | | |
| Chemotherapy | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | Inclusive of Primary Services | Not Covered | | Inclusive of Primary Service | Not Covered | |
| Chemotherapy Medications | | | | Covered in Full | Not Covered | | 20% Coinsurance<br>Subject to Deductible | Not Covered | |
| Infusion Therapy Outpatient | Inclusive of Primary Service<br>Subject to Deductible | Inclusive of Primary Service<br>Subject to Deductible | | $15 Copayment | Not Covered | | $40 Copayment | Not Covered | |
| Dialysis | $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | $15 Copayment | Not Covered | | $40 Copayment | Not Covered | |
| Mental Health Care | $25 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | | | | | | |
| Substance Use Care | $25 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | | | | | | |

## Home and Hospice Care

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **In Network** | **Out of Network** | **Limits** | | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| Covered in Full | Not Covered | | | Covered in Full | Not Covered | | $20 Copayment | Not Covered | 40 Visits per year |
| Covered in Full | Not Covered | | | Covered in Full | Not Covered | | Covered in Full | Not Covered | |

### 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | | | | | | |
| Home Infusion Therapy | $25 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | Covered in Full | Not Covered | | Covered in Full | Not Covered | |
| Home Dialysis | 0% Coinsurance<br>Subject to $50 Deductible | 25% Coinsurance<br>Subject to $50 Deductible | 120 Visits per year | | | | | | |

### Hospice Care

| Benefit Name | SimplyBlue Copay and Deductible Private Exchange In Network | SimplyBlue Copay and Deductible Private Exchange Out of Network | SimplyBlue Copay and Deductible Private Exchange Limits | Excellus BlueEPO Enhanced Plan In Network | Excellus BlueEPO Enhanced Plan Out of Network | Excellus BlueEPO Enhanced Plan Limits | Excellus BlueEPO Core Plan In Network | Excellus BlueEPO Core Plan Out of Network | Excellus BlueEPO Core Plan Limits |
|---|---|---|---|---|---|---|---|---|---|
| Hospice Care Inpatient | 0% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $15 Copayment | Not Covered | | PCP / Specialist - 20% Coinsurance<br>Subject to Deductible | 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $15 Copayment | Not Covered | | PCP / Specialist - $40 Copayment | Not Covered | |
| Diagnostic X-ray | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - $20 Copayment | Not Covered | |
| Diagnostic Laboratory and Pathology | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - $40 Copayment | Not Covered | |
| Radiation Therapy | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - $40 Copayment | Not Covered | |
| Chemotherapy | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Inclusive of Primary Services | Not Covered | | PCP / Specialist - Inclusive of Primary Service | Not Covered | |
| Infusion Therapy Services | PCP / Specialist - Inclusive of Primary Service<br>Subject to Deductible | Inclusive of Primary Service | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - 20% Coinsurance<br>Subject to Deductible | Not Covered | |
| Dialysis | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $15 Copayment | Not Covered | | PCP / Specialist - $40 Copayment | Not Covered | |
| Mental Health Care | PCP / Specialist - $25 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |
| Maternity Care | PCP / Specialist - $40 Copayment<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $15 Copayment | Not Covered | | Specialist - $40 Copayment<br>PCP - $20 Copayment | Not Covered | |
| Telehealth | Specialist - $40 Copayment<br>Subject to Deductible<br>PCP - $25 Copayment | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $5 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | | PCP / Specialist - $5 Copayment | Not Covered | |
| TeleMedicine Program | PCP / Specialist - $5 Copayment<br>Subject to Deductible | Not Covered | | PCP / Specialist - $15 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | | PCP / Specialist - $20 Copayment | Not Covered | |
| Chiropractic Care | Specialist - $40 Copayment<br>Subject to Deductible<br>PCP - $25 Copayment | 40% Coinsurance<br>Subject to Deductible | | PCP / Specialist - $15 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | | PCP / Specialist - $20 Copayment<br>$0 PCP Copay for members to age 19. | Not Covered | |
| | | | | PCP / Specialist - Not Covered | Not Covered | Not Covered | PCP / Specialist - Not Covered | Not Covered | Not Covered |

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|---|---|---|---|---|---|---|---|---|---|
| Allergy Testing | Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment | 40% Coinsurance Subject to Deductible | | $15 Copayment | Not Covered | 45 Visits per year | $40 Copayment | Not Covered | 45 Visits per year |
| Allergy Treatment Including Serum | Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment | 40% Coinsurance Subject to Deductible | | $15 Copayment | Not Covered | 45 Visits per year | $40 Copayment | Not Covered | 45 Visits per year |
| Hearing Evaluations Routine | Specialist - $40 Copayment Subject to Deductible PCP - $25 Copayment | 40% Coinsurance Subject to $5000 Deductible | 1 Exam Per Year | $15 Copayment | Not Covered | 45 Visits per year | $40 Copayment | Not Covered | 45 Visits per year |

## 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 | PCP / Specialist - $15 Copayment | Not Covered | 45 Visits per year | PCP / Specialist - $40 Copayment | Not Covered | 45 Visits per year |
| Occupational Rehabilitation | $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 | $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 |

### 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 - Covered in Full | Not Covered | 1 Exam per year | PCP / Specialist - Covered in Full | Not Covered | 1 Exam per year |
| Occupational Rehabilitation | PCP / Specialist - $40 Copayment Subject to Deductible | 40% Coinsurance Subject to Deductible | 60 Visits per year | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |
| Speech Rehabilitation | PCP / Specialist - $40 Copayment Subject to Deductible | 40% Coinsurance Subject to Deductible | 60 Visits per year | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |

## 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 | |
| | | | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |

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|---|---|---|---|---|---|---|---|---|---|
| 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 | | PCP / Specialist - Covered in Full | Not Covered | |
| Pre/Post-Natal Care | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | | | | | | | |
| Mammography Screening Professional | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | | 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 | | Covered in Full | Not Covered | 1 Exam per year | Covered in Full | Not Covered | |
| Bone Density Screening Professional | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | | Covered in Full | Not Covered | | Covered in Full | Not Covered | |
| | | | | Covered in Full | Not Covered | | Covered in Full | Not Covered | |
| | | | | Covered in Full | Not Covered | | 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 | | PCP / Specialist - $15 Copayment | Not Covered | | Specialist - $40 Copayment PCP - $20 Copayment | Not Covered | |
| Mammography Screening Facility | Covered in Full | 40% Coinsurance Subject to Deductible | | PCP / Specialist - Covered in Full | Not Covered | | PCP / Specialist - Covered in Full | Not Covered | |
| Colonoscopy Screening Facility | 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 Facility | Covered in Full | 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 - Professional**

| Benefit Name | In Network | Out of Network | Limits |
|---|---|---|---|
| Prostate Cancer Screening | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | |

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|---|---|---|---|---|---|---|---|---|---|
| Colonoscopy Screening Professional | PCP / Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | | Covered in Full | Not Covered | | Covered in Full | Not Covered | |
| Bone Density Screening Professional | PCP / Specialist - $40 Copayment Subject to Deductible | 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 - 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 and Deductible Private Exchange | | | Excellus BlueEPO Enhanced Plan | | | Excellus BlueEPO 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 | $50 Copayment | $50 Copayment | | $50 Copayment | $50 Copayment | |
| **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 | | $15 Copayment | $15 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 | | $25 Copayment | Not Covered | | $25 Copayment | Not Covered | |
| **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 | | $15 Copayment | Not Covered | 1 Exam per year | $20 Copayment | Not Covered | 1 Exam every year |
| **Ancillary Benefits** | | | | 20% Coinsurance | Not Covered | 1 Pair per year | 50% Coinsurance | Not Covered | 1 Pair every 2 years |
| **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 | Covered | Not Covered | $100 Reimbursement per year | Covered | Not Covered | $60 Reimbursement every 2 years |
| Adult Eye Exams - Routine | Not Covered | Not Covered | Not Covered | | | | | | |
| Adult Eyewear - Routine | Not Covered | Not Covered | Not Covered | | | | | | |
| **Rx Benefits** | | | | | | | | | |
| **Benefit Name** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** | **In Network** | **Out of Network** | **Limits** |
| | | | | | | $5/$20/$35 | | | $10/$30/$50 |

## SimplyBlue Copay and Deductible Private Exchange

### Rx Plan

| Benefit Name | In Network | Out of Network | Limits |
|---|---|---|---|
| Rx Plan | | | $10/$35/$70 EXCHANGE |

### Rx Benefits

| Benefit Name | In Network | Out of Network | Limits |
|---|---|---|---|
| Days Supply Per Retail Order | 90 | | |
| Days Supply Per Mail Order | 90 | | |
| Copays Per Mail Order Supply | 1 | | |

2339829 - 1

## Excellus BlueEPO Enhanced Plan

| In Network | Out of Network | Limits |
|---|---|---|
| 90 | | |
| 90 | | |
| 1 | | |

2380308 - 1

## Excellus BlueEPO Core Plan

| In Network | Out of Network | Limits |
|---|---|---|
| 90 | | |
| 90 | | |
| 1 | | |

2380310 - 1