

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

ROCHESTER CITY SCHOOL DISTRICT SimplyBlue Copay and Deductible Private Exchange

Excellus BlueEPO Enhanced Plan

Excellus BlueEPO Core Plan

General Information

Cost Snaring Expense	es '		1		•	
Benefit Name	In Network	Out of Network Limits	In Network	Out of Network Limits	In Network	Out of Network 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	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	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		L. N. de d	0.4.4(1).44	11		Out of National	1.5
Plan Limits				In Network	Out of Network	Limits	In Network	Out of Network	Limits
Benefit Name	In Network	Out of Network	Limits			Calendar Year Benefits			Calendar Year Benefits
Plan/Calendar Year			Calendar Year Benefits			No			No
Diabetic Preauthorization and Step Therapy			No				I		
14 11	I			In Network	Out of Network	Limits	In Network	Out of Network	Limits
Who is Covered						Not Covered			Not Covered

Excellus BlueEPO Enhanced Plan

Benefit Name	In Network	Out of Network	Limits						
Domestic Partner Coverage			Not Covered				1		
Inpatient Services				In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Services				Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Benefit Name	In Network	Out of Network	Limits	Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
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	120 Days per year	20% Coinsurance Subject to Deductible	Not Covered	120 Days per year
Substance Use Detoxification	\$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered	60 Days per year	20% Coinsurance Subject to Deductible	Not Covered	60 Days per year
Skilled Nursing Facility	\$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	\$200 Days per year	Covered in Full	Not Covered		20% Coinsurance	Not Covered	
Physical Rehabilitation	\$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year				Subject to Deductible		
Maternity Care	\$1,000 Copayment	40% Coinsurance Subject to Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Professional	 Services			PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Benefit Name	In Network	Out of Network	Limits	PCP / Specialist -	Not Covered		PCP / Specialist - 20% Coinsurance	Not Covered	
Inpatient Hospital Surgery	PCP / Specialist - \$1,000 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full			Subject to Deductible		
Anesthesia	PCP / Specialist - Covered in Full Subject to Deductible	Covered in Full Subject to \$600 Deductible					I		
Outpatient Facility	Services			In Network	Out of Network	Limits	In Network	Out of Network	Limits
Outpatient Facility Ser				\$15 Copayment	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Benefit Name	In Network	Out of Network	Limits	\$15 Copayment	Not Covered		\$40 Copayment	Not Covered	
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$100 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		\$20 Copayment	Not Covered	

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 Subject to Deductible	40% Coinsurance Subject to Deductible		Covered in Full	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		\$40 Copayment	Not Covered	
Radiation Therapy	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible							
Chemotherapy	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Inclusive of Primary Services	Not Covered		Inclusive of Primary Service	Not Covered	
Chemotherapy Medications				Covered in Full	Not Covered		20% Coinsurance Subject to Deductible	Not Covered	
Infusion Therapy Outpatient	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible		\$15 Copayment	Not Covered		\$40 Copayment	Not Covered	
Dialysis	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		\$15 Copayment	Not Covered		\$40 Copayment	Not Covered	
Mental Health Care	\$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible							
Substance Use Care	\$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home and Hospice	Care			Covered in Full	Not Covered		\$20 Copayment	Not Covered	40 Visits per year
Home Care Benefit Name	In Network	Out of Network	Limits	Covered in Full	Not Covered		Covered in Full	Not Covered	
Home Care	\$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible					· I		
Home Infusion Therapy	\$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		In Network Covered in Full	Out of Network Not Covered	Limits	In Network Covered in Full	Out of Network Not Covered	Limits
Home Dialysis	0% Coinsurance Subject to \$50 Deductible	25% Coinsurance Subject to \$50 Deductible	120 Visits per year						

Hospice Care

Excellus BlueEPO Enhanced 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		PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - 20% Coinsurance Subject to Deductible	Not Covered	
Outpatient and Off	fice Profession	onal Services	8	PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - \$40 Copayment	Not Covered	
Professional Services				PCP / Specialist -			PCP / Specialist - \$20		
Benefit Name	In Network	Out of Network	Limits	Covered in Full	Not Covered		Copayment Copayment	Not Covered	
Office Surgery	PCP / Specialist - \$100 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - \$40 Copayment	Not Covered	
Diagnostic X-ray	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	
Diagnostic Laboratory and Pathology	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Inclusive of Primary Services	Not Covered		PCP / Specialist - Inclusive of Primary Service	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 - 20% Coinsurance Subject to Deductible	Not Covered	
Chemotherapy	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	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 - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Dialysis	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	Not Covered		Specialist - \$40 Copayment PCP - \$20 Copayment	Not Covered	
Mental Health Care	PCP / Specialist - \$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$5 Copayment \$0 PCP Copay for members to age 19.	Not Covered		PCP / Specialist - \$5 Copayment	Not Covered	
Maternity Care	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - \$20 Copayment	Not Covered	
Telehealth	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	
TeleMedicine Program	PCP / Specialist - \$5 Copayment Subject to Deductible	Not Covered		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	
Chiropractic Care	Specialist - \$40 Copayment Subject to Deductible PCP - \$25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Excellus BlueEPO Enhanced Plan

Benefit Name	In Network	Out of Network	Limits						
Allergy Testing	Specialist - \$40 Copayment Subject to Deductible PCP - \$25 Copayment	40% Coinsurance Subject to Deductible		In National	Out of Native de	Limite	La Naturale	Out of Native de	Limite
Allergy Treatment Including Serum	Specialist - \$40 Copayment Subject to Deductible PCP - \$25 Copayment	40% Coinsurance Subject to Deductible		In Network \$15 Copayment	Out of Network Not Covered	Limits 45 Visits per year	In Network \$40 Copayment	Out of Network Not Covered	Limits 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 Habilita	ation								
Outpatient Facility				\$15 Copayment	Not Covered	45 Visits per year	\$40 Copayment	Not Covered	45 Visits per year
Benefit Name	In Network	Out of Network	Limits						
Physical Rehabilitation	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	In Network	Out of Network	Limits	In Network	Out of Network	Limits
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 Profession	,	Subject to Deductible		PCP / Specialist - \$15 Copayment	Not Covered	45 Visits per year	PCP / Specialist - \$40 Copayment	Not Covered	45 Visits per year
Benefit Name	In Network	Out of Network	Limits						
Physical Rehabilitation	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year				I		
Occupational Rehabilitation	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	In Network PCP / Specialist -	Out of Network Not Covered	1 Exam per year	In Network PCP / Specialist -	Out of Network Not Covered	Limits 1 Exam per year
Speech Rehabilitation	PCP / Specialist - \$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible	60 Visits per year	Covered in Full PCP / Specialist - Covered in Full	Not Covered	. 1. 7.	Covered in Full PCP / Specialist - Covered in Full	Not Covered	
Preventive Service	es								
Preventive Profession	reventive Professional Services Meeting Federal Guidelines*		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered		
Benefit Name	In Network	Out of Network	Limits	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	
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Excellus BlueEPO Enhanced 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		PCP / Specialist - Covered in Full	Not Covered	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		In Notwork	Out of Network	Limits	In Network	Out of Network	Limito
Mammography Screening	PCP / Specialist -	40% Coinsurance		In Network	Out of Network	Limits	in Network	Out of Network	Limits
Professional	Covered in Full	Subject to Deductible		Covered in Full	Not Covered	1 Exam per year	Covered in Full	Not Covered	
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 - Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	Not Covered		Covered in Full	Not Covered	
Preventive Facility Services Meeting Federal Guidelines*									
Benefit Name	In Network	Out of Network	Limits	Covered in Full	Not Covered		Covered in Full	Not Covered	
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	Not Covered	Lillius	Specialist - \$40 Copayment PCP - \$20 Copayment	Not Covered	Lillits
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	n to those required	under Federal Guide	lines - Professional	PCP / Specialist -			PCP / Specialist -		
Benefit Name	In Naturals	Out of Network	Limits	Covered in Full	Not Covered		Covered in Full	Not Covered	
Deficit Name	In Network	- Cut of Hothork							
Prostate Cancer Screening	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible							

Excellus BlueEPO Enhanced Plan

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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		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 addit	tion to those requi	ed under Federal (Guidelines - Facility	Covered in Full	Not Covered		Covered in Full	Not Covered	
Benefit Name	In Network	Out of Network	Limits						
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible							
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Bone Density Screening Facility	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - \$20 Copayment	Not Covered	
Other Benefits	,	•		PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - \$20 Copayment	Not Covered	
Additional Benefits	I			PCP / Specialist - \$15 Copayment	Not Covered		PCP / Specialist - \$20 Copayment	Not Covered	
Benefit Name	In Network	Out of Network	Limits	PCP / Specialist - 20%			PCP / Specialist - 50%		
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - \$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		Coinsurance	Not Covered		Coinsurance	Not Covered	
Treatment of Diabetes - Insulin	PCP / Specialist - \$25 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 50% Coinsurance	Not Covered	
Diabetic Equipment	PCP / Specialist - \$25 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		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
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered						

Excellus BlueEPO Enhanced Plan

Diagnoses				In Network	Out of Network	Limits	In Network	Out of Network	Limits
Benefit Name	In Network	Out of Network	Limits	\$50 Copayment	\$50 Copayment		\$50 Copayment	\$50 Copayment	
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Not Covered	Not Covered	Not Covered						
Emergency Service	es			In Network	Out of Network	Limits	In Network	Out of Network	Limits
ER Facility				\$15 Copayment	\$15 Copayment		\$50 Copayment	\$50 Copayment	
Benefit Name	In Network	Out of Network	Limits						
Facility Emergency Room Visit	\$150 Copayment Subject to Deductible	\$150 Copayment Subject to \$600 Deductible		In Network	Out of Network	Limits	In Network	Out of Network	Limits
Transportation				\$25 Copayment	Not Covered		\$25 Copayment	Not Covered	
Benefit Name	In Network	Out of Network	Limits						
Prehospital Emergency and Transportation - Ground or Water	\$150 Copayment Subject to Deductible	\$150 Copayment Subject to \$600 Deductible							
Urgent Care				In Network	Out of Network	Limits	In Network	Out of Network	Limits
Benefit Name	In Network	Out of Network	Limits	\$15 Copayment	Not Covered	1 Exam per year	\$20 Copayment	Not Covered	1 Exam every year
Urgent Care Center Facility Visit	\$40 Copayment Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance	Not Covered	1 Pair per year	50% Coinsurance	Not Covered	1 Pair every 2 years
Ancillary Benefits									
Vision				\$15 Copayment	Not Covered	1 Exam per year	\$20 Copayment	Not Covered	1 Exam every year
Benefit Name	In Network	Out of Network	Limits	Covered	Not Covered	\$100 Reimbursement	Covered	Not Covered	\$60 Reimbursement
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered			per year			every 2 years
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered				ı		
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Addit Lyo Litanio - Mounic	1101 0076160	1401 0076150	1,01 0076160			\$5/\$20/\$35			\$10/\$30/\$50
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered						
Rx Benefits	•			•					

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Excellus BlueEPO Core Plan

Rx Plan				In Network	Out of Network	Limits	In Network	Out of Network	Limits
Benefit Name	In Network	Out of Network	Limits	90			90		
Rx Plan			\$10/\$35/\$70 EXCHANGE	90			90		
Rx Benefits									
Benefit Name	In Network	Out of Network	Limits	1			1		
Days Supply Per Retail Order	90				2380308 - 1			2380310 - 1	
Days Supply Per Mail Order	90								
Copays Per Mail Order Supply	1								
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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.