

Union Endicott Central School District

Side-by-Side Benefits Comparison: Excellus Classic Blue Indemnity & Excellus LTD Medicare Advantage

PLAN OVERVIEW	CURRENT - Excellus BCBS		NEW - Excellus BCBS	
	Classic Blue Indemnity		Medicare Blue PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single / Family)	\$100 / \$300		None	\$0
Retiree Coinsurance	20%		0%	10%
Maximum Out-of-Pocket (Single / Family)	\$400 / \$1,200 (combined medical and Rx)		All medical services covered at \$0 copay \$1,250 (medical only)	\$8,000 ((\$2,500 cap/remaining paid by District))
Primary Care Office Visit	Subject to Deductible & Coinsurance		\$0 copay	10% coinsurance
Specialist Office Visit	Subject to Deductible & Coinsurance		\$0 copay	10% coinsurance
PRESCRIPTION DRUGS				
Pharmacy Retail (30-day supply)	Subject to Deductible & Coinsurance		\$2 / \$10 / \$10 / \$10 <i>No Prior Authorization or Step Therapy</i>	Covered at in-network cost sharing in emergency situations only
Pharmacy Mail-Order (90-day supply)	Same as Pharmacy Retail		\$2 / \$10 / \$10 / \$10	
Maximum Out-of-Pocket Pharmacy Only	\$400 / \$1,200 (combined medical and Rx)		\$400 max (Excellus pays 100% for remainder of plan year)	
Coverage Gap	Not Applicable		None	
Catastrophic Coverage	Not Applicable		\$2 / \$10 / \$10 / \$10	
INPATIENT HOSPITAL				
Inpatient Hospitalization	Covered in Full		\$0 copay	10% coinsurance
Inpatient Physician Visit	Covered in Full		\$0 copay	10% coinsurance
Skilled Nursing Facility	Covered in Full		\$0 copay	10% coinsurance
Emergency Room Services	Covered in Full		\$0 copay (Worldwide Coverage)	
Urgent Care	Covered in Full		\$0 copay (Worldwide Coverage)	
OUTPATIENT SERVICES				
Outpatient Surgery	Covered in Full		\$0 copay	10% coinsurance
Diagnostic office visits	Subject to Deductible & Coinsurance		\$0 copay	10% coinsurance
Diagnostic Laboratory Tests	Covered in Full		\$0 copay	10% coinsurance
Radiological Services (X-rays)	Covered in Full		\$0 copay	10% coinsurance
Allergy Testing / Injections	Subject to Deductible & Coinsurance		\$0 copay	10% coinsurance
Chemotherapy	Covered in Full		\$0 copay	10% coinsurance
Radiation Therapy	Covered in Full		\$0 copay	10% coinsurance
Dialysis	Covered in Full		\$0 copay	10% coinsurance
Acupuncture	Not Covered		\$0 copay, up to 20 visits per year	
Ambulance	Covered in Full		\$0 copay	
Hospice Care	Covered in Full for Unlimited Days		Covered by Original Medicare	
Home Healthcare Services	Covered in Full up to 60 visits per year, then 20% after deductible up to 325 visits per year		\$0 copay	10% coinsurance
Rehabilitation Services: Physical, Speech, Occupational, Pulmonary, Cardiac	Subject to Deductible & Coinsurance		\$0 copay	10% coinsurance
Chiropractic Services	Subject to Deductible & Coinsurance		Medicare Covered (Spinal Manipulation): \$0 copay	
PREVENTIVE CARE				
Routine Physical Exam	Covered in Full		\$0 copay	10% coinsurance
Immunizations	Covered in Full		\$0 copay	10% coinsurance
Mammography	Covered in Full		\$0 copay	10% coinsurance
Prostate Exam	Covered in Full		\$0 copay	10% coinsurance
Bone Density Test	Covered in Full		\$0 copay	10% coinsurance
Pelvic Exam / PAP Smear	Covered in Full		\$0 copay	10% coinsurance
VISION / HEARING				
Routine Vision / Hearing Exam	Not Covered		Vision: \$0 copay Hearing: \$0 copay (TruHearing providers only)	Vision: 10% coinsurance Hearing: \$75 copay
Eyewear Frames/Lenses or Contacts Allowance	Not Covered		\$100 Allowance per year	
Hearing Aid Allowance	Not Covered		\$699 copay Advanced Aids \$999 copay Premium Aids (TruHearing Providers only; copay is per hearing aid)	
DURABLE MEDICAL EQUIPMENT / DIABETIC SUPPLIES				
Durable Medical Equipment & Prosthetic Devices	Subject to Deductible & Coinsurance		\$0 copay Orthotics (Diabetic Diagnosis)	10% coinsurance
Diabetic Supplies, Equipment and Education	Covered in Full		\$0 copay	10% coinsurance
MENTAL HEALTH & CHEMICAL DEPENDENCY				
Inpatient	Covered in Full		\$0 copay	10% coinsurance
Outpatient	Mental Health: Subject to Deductible & Coinsurance Chemical Dependency: \$0 copay, unlimited visits		\$0 copay	10% coinsurance
ADDITIONAL BENEFITS				
International Coverage	Coverage provided worldwide through the BlueCard® program		100% paid for by Excellus; Limited to Emergency Room & Urgent Care	
FITNESS ALLOWANCE				
Lifestyle & Wellness	Blue365 Wellness - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.		Silver & Fit Program - Exercise Program that gives you the choice of: > Membership in fitness Club/exercise center (\$25 annual fee) > Home Fitness Program (\$10 annual fee) > \$150 annual reimbursement toward paid membership at a non-participating facilities > Blue 365; Exclusive online discounts to health related products and services > Silver&Fit copays will not be included in the Annual Out-of-Pocket Maximum	
RATES				
		Monthly Rate (2021 - 2022)	Monthly Rate (2022)	
	Single	\$861.29	\$302.00	
	Family	\$2,135.74	\$604.00	
RATES				
		RETIREE ANNUAL COST (5%)	RETIREE ANNUAL COST (5%)	
	Single	\$516.77	\$181.20	
	Family	\$1,281.44	\$362.40	

Benefit Comparison is for illustrative purposes. Please refer to detail benefit summary & contract for actual coverage.

Emergencies services covered in and Out-of-Network

Covered in Full = \$0 copay