Excellus

Finger Lakes Area School Health Plan

Benefit Comparison
Benefit Time Period 07/01/2017 - 06/30/2018

General Information

Cost Sharing Expenses

Benefit Name	BluePoint2 $5/$10 In Network	BluePoint2 $5/$10 Out of Network	BluePoint2 $5/$10 Limits	BluePoint2 $15 In Network	BluePoint2 $15 Out of Network	BluePoint2 $15 Limits	Healthy Blue Copay $15/$25 In Network	Healthy Blue Copay $15/$25 Out of Network	Healthy Blue Copay $15/$25 Limits
Deductible - Single	$0	$300		$0	$300		$0	$500	
Deductible - Family	$0	$750		$0	$750		$0	$1,500	
Coinsurance	0%	25%		0%	25%		0%	20%	
Annual Out of Pocket Maximum - Single	$6,350	$6,350		$6,350	$6,350		$4,200	$4,200	
Annual Out of Pocket Maximum - Family	$12,700	$12,700		$12,700	$12,700		$12,600	$12,600	
Annual Out of Pocket Maximum - Per Person Cap	$6,350	$6,350		$6,350	$6,350		$4,200	$4,200	

Office Visit Cost Shares

Benefit Name	BluePoint2 $5/$10 In Network	BluePoint2 $5/$10 Out of Network	BluePoint2 $5/$10 Limits	BluePoint2 $15 In Network	BluePoint2 $15 Out of Network	BluePoint2 $15 Limits	Healthy Blue Copay $15/$25 In Network	Healthy Blue Copay $15/$25 Out of Network	Healthy Blue Copay $15/$25 Limits
Cost Share - Primary Care	$5 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$10 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	$5 PCP/ $10 Specialist Copayment	25% Coinsurance Subject to Deductible		$5 PCP OV and Treatment for sick kids to age 19	25% Coinsurance Subject to Deductible		$0 copayment for dependents to age 19 on all In-Network PCP office visits.	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	BluePoint2 $5/$10 In Network	BluePoint2 $5/$10 Out of Network	BluePoint2 $5/$10 Limits	BluePoint2 $15 In Network	BluePoint2 $15 Out of Network	BluePoint2 $15 Limits	Healthy Blue Copay $15/$25 In Network	Healthy Blue Copay $15/$25 Out of Network	Healthy Blue Copay $15/$25 Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			No			Yes

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		
Who is Covered									
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	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		$150 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		$150 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		$150 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	25% Coinsurance Subject to Deductible	120 Days Per Year	Covered in Full	25% Coinsurance Subject to Deductible	120 Days Per Year	$150 Copayment	20% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Habilitation Services	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	25% Coinsurance Subject to Deductible	60 Days per year	$150 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
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 - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full	

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		

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	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		$75 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$10 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive to Primary Service	Inclusive to Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	$10 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Care	$10 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	

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	Covered in Full	25% Coinsurance Subject to $50 Deductible		Covered in Full	25% Coinsurance Subject to $50 Deductible		Covered in Full	20% Coinsurance Subject to $50 Deductible	40 Visits per year

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	BluePoint2 $5/$10 In Network	BluePoint2 $5/$10 Out of Network	BluePoint2 $5/$10 Limits	BluePoint2 $15 In Network	BluePoint2 $15 Out of Network	BluePoint2 $15 Limits	Healthy Blue Copay $15/$25 In Network	Healthy Blue Copay $15/$25 Out of Network	Healthy Blue Copay $15/$25 Limits
Office Surgery	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		Specialist - $25 Copayment PCP - $15 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chiropractic Care	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - $10 Copayment PCP - $5 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		Specialist - $25 Copayment PCP - $15 Copayment	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	Specialist - $10 Copayment PCP - $5 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		Specialist - $25 Copayment PCP - $15 Copayment	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per Year

Rehab and Habilitation

Outpatient Facility

Benefit Name	BluePoint2 $5/$10 In Network	BluePoint2 $5/$10 Out of Network	BluePoint2 $5/$10 Limits	BluePoint2 $15 In Network	BluePoint2 $15 Out of Network	BluePoint2 $15 Limits	Healthy Blue Copay $15/$25 In Network	Healthy Blue Copay $15/$25 Out of Network	Healthy Blue Copay $15/$25 Limits
Physical Rehabilitation	$10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Occupational Rehabilitation	$10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	$25 Copayment	20% Coinsurance Subject to Deductible	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 - $10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible	30 Visits per calendar year	PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	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	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	2 Exam per year	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible	2 Exam per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care 2nd Tier	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		
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	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

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	25% Coinsurance Subject to Deductible	2 per year	Covered in Full	25% Coinsurance Subject to Deductible	2 per year	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

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	Specialist - $10 Copayment PCP - $5 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - $10 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	

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	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Colonoscopy Screening Facility	Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	25% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$10 Copayment	25% Coinsurance Subject to Deductible		$15 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Diabetic Equipment	PCP / Specialist - $5 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	25% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - Not Covered	Not Covered		PCP / Specialist - Not Covered	Not Covered		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per calendar year	PCP / Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	10 Visits per 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

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	$50 Copayment	$50 Copayment		$50 Copayment	$50 Copayment		$75 Copayment	$75 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	$25 Copayment	$25 Copayment		$25 Copayment	$25 Copayment		$75 Copayment	$75 Copayment	

	BluePoint2 $5/$10			BluePoint2 $15			Healthy Blue Copay $15/$25		
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	$25 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	25% Coinsurance Subject to Deductible		$25 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Eye Exams - Routine	$10 Copayment	Not Covered	1 Exam every 2 calendar years	$15 Copayment	Not Covered	1 Exam every 2 calendar years	$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Eyewear - Routine	Covered	25% Coinsurance Subject to Deductible	$60 Reimbursement every 2 calendar years	Covered	Not Covered	$60 Reimbursement every 2 calendar years	Covered	Covered	$60 Reimbursement Per year
Pediatric Eye Exams - Routine	$10 Copayment	Not Covered	1 Exam per calendar year	$15 Copayment	Not Covered	1 Exam per calendar year	$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year
Pediatric Eyewear - Routine	Covered	25% Coinsurance Subject to Deductible	$60 Reimbursement per calendar year	Covered	Not Covered	$60 Reimbursement per calendar year	Covered	Covered	$60 Reimbursement Per year

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			$0/$30/$50			$0/$30/$50			$5/$25/$50, $0 Gen for Kids

Rx Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	90			90			30		
Days Supply Per Mail Order	90			90			90		
Copays Per Mail Order Supply	2			2			2		