CHENANGO FORKS CENTRAL SCHOOL DISTRICT RETIREE BENEFIT COMPARISON

Benefit	Excellus BCBS Classic Blue Plan	Excellus BCBS Blue PPO (In-Network)	Excellus BCBS Blue PPO Plan (Out of Network)	Medicare 2020 Benefits	Excellus Medicare Supplement Plan F/G	Excellus compared to Excellus CB	Excellus compared to Excellus In-Net PPO	Humana MAPD	Humana compared to Excellus CB	Humana compared to Excellus In-Net PPO	Aetna MAPD	Aetna compared to Excellus CB	Aetna compared to Excellus In-Net PPO
Deductible Calendar Year	Individual $50 Family $150	None	Individual $250 Family $750	Part A $1,408 Part B $198	Covered	+	=	None	+	=	None	+	=
Standard Copayment	N/A	$10	N/A	None	None	=	+	$0	=	+	$0	=	+
Standard Co-insurance	20%	N/A	20%	20%	Covered	+	=	N/A	+	=	N/A	+	=
Out-of-Pocket Maximum	Individual $400 Family $1,200 (Excluding deductible)	None	Individual $1,000 Family $3,000 (Includes deductible)	None	None	N/A	=	None	N/A	=	None	N/A	=
Lifetime Maximums	Unlimited	Unlimited		Unlimited	Unlimited	=	=	Unlimited	=	=	Unlimited	=	=
PHYSICAN OFFICE SERVICES													
Office Visit	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Chiropractic Care	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	**Spinal Manipulation:** Subject to Part B $198 deductible & 80% coinsurance	**Medicare Covered (Spinal Manipulation)**: 100% after Medicare	+	+	**Medicare Covered (Spinal Manipulation)**: $0 copay **Non-Medicare Covered (Routine Maintenance Care)**: $0 copay	+	+	**Medicare Covered (Spinal Manipulation)**: $0 copay **Non-Medicare Covered (Routine Maintenance Care)**: $0 copay	+	+
PREVENTIVE HEALTH CARE SERVICES													
Routine Physical Examinations	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% wellness yearly visit	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=
Adult Immunizations	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% coverage for pneumonia, influenza and hepatitis B vaccines	100% after Medicare	=	=	$0 copay	=	=	$0 copay (Pneumococcal, Flu, Hepatitis B)	=	=
Mammography Screening	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% Coverage	100% after Medicare	=	=	$0 copay	=	=	$0 copay; One baseline mammogram for members age 35-39 and one annual screening for members age 40 and over	=	=
Pap Smear	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% Coverage	100% after Medicare	=	=	$0 copay	=	=	$0 copay (one every 12 months)	=	=
Prostate Cancer Screening	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% Coverage	100% after Medicare	=	=	$0 copay	=	=	$0 copay; For covered males age 50 and over, every 12 months	=	=
Bone Density Tests	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	100% Coverage	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=

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Routine Vision Exams	Not covered	Not covered	Not covered	Not covered	Not covered	=	=	$0 copay	+	+	$0 copay; One annual exam every 12 months	+	+
Eyewear – Frames/Lenses or contacts	Covered after cataract surgery	Covered after cataract surgery	Not covered	Subject to Part B $198 deductible & 80% coinsurance; Medicare will cover one pair of glasses following intraocular surgery ONLY – no routine eyewear coverage	100% after Medicare (cataract surgery)	=	=	Medicare Covered (after cataract surgery): $0 copay Non-Covered Medicare: $100 allowance Vision discounts available through EyeMed	+	+	Medicare covered services (after cataract surgery) - $0 copay; Non-Medicare covered services - $100 allowance every 12 months	+	+
Hearing Evaluations Diagnostic	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay; One annual exam every 12 months	+	+	$0 copay; One annual exam every 12 months	+	+
Hearing Aids	Not covered	Not covered	Not covered	Not Covered	Not covered	=	=	$600 allowance (Discounts available through TruHearing (Non-Fla residents) and HearUSA (Fla residents only)	+	+	$600 allowance every 36 months	+	+
INPATIENT SERVICES													
Inpatient Hospital	Covered in full	Covered in full (Pre-Authorization Required)	Subject to deductible & 20% coinsurance (Pre-Authorization Required)	100% Coverage EXCEPT Part A deductible of $1,408 Days 61-90 coinsurance amount of $352 per day; Days 91 and after (Medicare Reserve Days) coinsurance amount of $704 per day; Benefits exhausts after 150 days. Once member is discharged for at least 60 days benefit period starts over (deductible and coinsurance) up to 90 days of coverage if Medicare Reserve Days are exhausted	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=
Inpatient Physician Visit	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=
Inpatient Mental Health	Covered in full	Covered in full (Pre-Authorization Required)	Subject to deductible & 20% coinsurance (Pre-Authorization Required)	100% Coverage EXCEPT Part A deductible of $1,408 Days 61-90 coinsurance amount of $352 per day; Days 91 and after (Medicare Reserve Days) coinsurance amount of $704 per day; Benefits exhausts after 150 days. Once member is discharged for at least 60 days benefit period starts over (deductible and coinsurance) up to 90 days of coverage if Medicare Reserve Days are exhausted	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=

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Benefit	Excellus BCBS Classic Blue Plan	Excellus BCBS Blue PPO (In-Network)	Excellus BCBS Blue PPO Plan (Out of Network)	Medicare 2020 Benefits	Excellus Medicare Supplement Plan F/G	Excellus compared to Excellus CB	Excellus compared to Excellus In-Net PPO	Humana MAPD	Humana compared to Excellus CB	Humana compared to Excellus In-Net PPO	Aetna MAPD	Aetna compared to Excellus CB	Aetna compared to Excellus In-Net PPO
Inpatient Substance Abuse	Covered in full	Covered in full (Pre-Authorization Required)	Subject to deductible & 20% coinsurance (Pre-Authorization Required)	100% Coverage EXCEPT Part A deductible of $1,408 Days 61-90 coinsurance amount of $352 per day; Days 91 and after (Medicare Reserve Days) coinsurance amount of $704 per day; Benefits exhausts after 150 days. Once member is discharged for at least 60 days benefit period starts over (deductible and coinsurance) up to 90 days of coverage if Medicare Reserve Days are exhausted	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=
Skilled Nursing Facility (SNF) Inpatient	Covered in full	Covered in full up to 120 days per SNF stay - 90 day renewal (Pre-Authorization Required)	Subject to deductible & 20% coinsurance up to 120 days per SNF stay - 90 day renewal (Pre-Authorization Required)	100% Coverage Day 1-20; Day 21-100 all except $176 a day; 101st day and after No Coverage	100% after Medicare; Plan pays $0 after 100 days	-	-	$0 copay (Unlimited days per benefit period)	=	+	$0 copay (Unlimited days per benefit period)	=	+
EMERGENCY CARE													
Emergency Room	Paid in full	$50 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	+	$0 copay	=	+	$0 copay (Includes worldwide coverage)	=	+
Urgent Care Visit	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay (Includes worldwide coverage)	+	+
OUTPATIENT BENEFITS													
Outpatient Surgery	Paid in full	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	+	$0 copay	=	+	$0 copay	=	+
Office Surgery	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Diagnostic Laboratory Tests	Paid in full	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	+	$0 copay	=	+	$0 copay	=	+

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Benefit	Excellus BCBS Classic Blue Plan	Excellus BCBS Blue PPO (In-Network)	Excellus BCBS Blue PPO Plan (Out of Network)	Medicare 2020 Benefits	Excellus Medicare Supplement Plan F/G	Excellus compared to Excellus CB	Excellus compared to Excellus In-Net PPO	Humana MAPD	Humana compared to Excellus CB	Humana compared to Excellus In-Net PPO	Aetna MAPD	Aetna compared to Excellus CB	Aetna compared to Excellus In-Net PPO
Radiation Therapy	Paid in full	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	+	$0 copay	=	+	$0 copay	=	+
Chemotherapy	Paid in full	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	+	$0 copay	=	+	$0 copay	=	+
Outpatient Mental Health Professional	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Alcohol/Substance Abuse Facility Outpatient	Paid in full (60 visits per calendar year; Additional days may be available)	Covered in full	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	=	$0 copay	+	=	$0 copay	+	=
OTHER SERVICES													
Therapies: Physical, Speech, Occupational, Pulmonary, Cardiac	Subject to deductible & 20% coinsurance	$10 copay (Max of 45 days combined PT, OT & ST)	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Diabetic Supplies, Equipment and Education	Subject to deductible & 20% coinsurance	$10 copay	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance; Medicare covers education at 100%	100% after Medicare	+	+	$0 copay	+	+	$0 copay (Includes supplies to monitor blood glucose)	+	+
Durable Medical Equipment	Subject to deductible & 20% coinsurance	20% coinsurance	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Prosthetics	Subject to deductible & 20% coinsurance (No calendar year maximum)	20% coinsurance ($15,000 calendar year max)	Subject to deductible & 20% coinsurance ($15,000 calendar year max)	Subject to Part B $198 deductible & 80% coinsurance; Medicare does not cover Routine Foot Orthotics MUST be medically necessary	100% after Medicare	+	+	$0 copay	+	+	$0 copay	+	+
Home Health Care	Paid in full (60 visits with 325 additional visits under Enhanced Benefits)	Covered in full (unlimited visits)	Subject to deductible & 20% coinsurance	Part A services Covered in Full, Part B Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	+	=	$0 copay	+	=	$0 copay	+	=
Hospice Care	Paid in full up to 210 days	Covered in full (unlimited days)	Subject to deductible & 20% coinsurance	All but very limited coinsurance for outpatient drugs and inpatient respite care	100% after Medicare	+	=	$0 copay	+	=	$0 copay	+	=
Dialysis	Paid in full	Paid in full	Subject to deductible & 20% coinsurance	Subject to Part B $198 deductible & 80% coinsurance	100% after Medicare	=	=	$0 copay	=	=	$0 copay	=	=
Acupuncture	Not covered	Not covered		Not covered	Not covered	=	=	$0 copay	+	+	$0 copay	+	+

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International Coverage	TBD	TBD		Not Covered	Emergencies covered within the first 60 days of travel. Subject to a $250 Deductible and 20% Coinsurance, $50,000 Lifetime Maximum	-	-	100% paid by Humana; Limited to emergency Medicare-covered services.		=	=	$0 copay for Emergency Room and Urgent Care		=	=
Lifestyle/Wellness Benefits	None	None		None	None	=	=	Silver Sneakers		+	+	Resources for Living/ Silver Sneakers		+	+
PRESCRIPTION DRUGS															
Generic	$2	$5	N/A		$2	=	**TBD**	$2	$5	=	=	$2	$5	=	=
Preferred Brand	$10	$15	N/A		$10	=	**TBD**	$10	$15	=	=	$10	$15	=	=
Non-Preferred Brand	$10	$30	N/A		$10	=	**TBD**	$10	$30	=	=	$10	$30	=	=
Specialty	See above	See above	N/A		See above	=	**TBD**	$10	$30	Depends on tier	Depends on tier	See above	See above	=	=
90 Day Supply	$2/$10/$10	$15/$45/$90	N/A		$2/$10/$10	=	**TBD**	$2/$10/$10	$15/$45/$90	=	=	$2/$10	$15/$45/$90	=	=
Annual Deductible	$0	$0	N/A		$0	=	**TBD**	$0	$0	=	=	$0	$0	=	=
Annual Out of Pocket	None	Individual $3,000 Family $6,000	N/A		None	=	**TBD**	None	$3,000	=	=	None	2020: $1,500 2021: $3,000	=	+
Prescription Drug Formulary	Open	Closed		Dependent on Part D Plan	Closed	=	**TBD**	Open		=	+	Open		=	+
NETWORKS															
Medical	Excellus	Excellus		Medicare	Passive	+	**TBD**	Passive		+	+	Passive		+	+
RATES															
	Excellus BCBS Classic Blue Plan	**Excellus BCBS Blue PPO Plan**			**Excellus Medicare Supplement Plan F/G 6 month rate guarantee**		**TBD**	**Humana PPO-1 18 month rate guarantee**	**Humana PPO-2 18 month rate guarantee**			**Aetna Plan 1 18 month rate guarantee**	**Aetna Plan 2 18 month rate guarantee**		
Medical	Single: $813.92 Family: $2,035.97	Single: $759.85 Family: $1,885.81			Plan F: 199.09 Plan G: $183.00		**TBD**	$330.28	$270.89			$369.19	$337.78		
Prescription	Included	Included			$290.45		**TBD**	Included	Included			Included	Included		
Total Medical with Rx	Single: $813.92 Family: $2,035.97	Single: $759.85 Family: $1,885.81			$489.54	+	**TBD**	$330.28	$270.89	+	+	$369.19	$337.78	+	+
Projected Monthly Cost	$268,281	$7,937			$138,540	+	**TBD**	$91,488	$1,625	+	+	$102,266	$2,027	+	+
Projected Annual Cost	**$3,314,621**				**$1,807,037**	+	**TBD**	**$1,261,914**		+		**$1,396,067**		+	
All Eligible	Yes				Yes			Yes				Yes			
Estimated Savings					**$1,507,584**		**TBD**	**$2,052,707**				**$1,918,554**			