RASHP II - Value

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$750	
Deductible - Family	$0	$2,250	Each individual does not exceed the single deductible.
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single Deductible. Individual
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	$4,200	$4,200	All cost shares accumulate to the OOP Maximum (Deductible, Coinsurance, and Copays, including Rx Copays). One single OOP Max for both INN and OON combined.
Annual Out of Pocket Maximum - Family	$12,600	$12,600	Each individual does not exceed the single out of pocket maximum.
Annual Out of Pocket Maximum - Per Person Cap	N/A	N/A	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.
Annual Out of Pocket Maximum Aggregation - Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum. Any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 Copayment	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Varies by school district Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$100 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$100 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$100 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$100 Copayment	20% Coinsurance Subject to Deductible	120 Days per year 360 Days per lifetime. Limits are combined INN and OON.
Physical Rehabilitation	$100 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	$100 Copayment	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$50 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$20 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$20 Copayment	20% Coinsurance Subject to Deductible	
Lung Cancer Screening Outpatient	Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Dialysis	$20 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Substance Use Care	$20 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible	

Hospice Care

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

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Lung Cancer Screening Services	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	NYS Mental Health and Substance Use Disorder (SUD) Provision Applies.
Maternity Care	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	INN: 20% Coinsurance or $100 Copayment, whichever is less. NYS Maternal Depression Screening Mandate Applies.
Telehealth	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $10 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.

Benefit Name	In Network	Out of Network	Limits and Additional Information
Teledermatology	PCP/Specialist - $20 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate with MDLive.
Chiropractic Care	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $20 Copayment	Not Covered	1 Exam per calendar year

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	Not Covered	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	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 and Additional Information
Prostate Cancer Screening	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	NYS Mammography Screening Mandate Applies - One Annual Mammogram for ages 35-39.
Colonoscopy Screening Professional	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $20 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 and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	NYS Mammography Screening Mandate Applies - One Annual Mammogram for ages 35-39.
Colonoscopy Screening Facility	$50 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$20 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	Not Covered	
Medical Supplies	PCP/Specialist - Not Covered	Not Covered	Not Covered
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$50 Copayment	$50 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$50 Copayment	$50 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	$25 Copayment	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$20 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per calendar year
Adult Eye Exams - Routine	$20 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Covered	Not Covered	$60 Reimbursement every 2 calendar years

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$10/$25/$40

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	3		

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.