Excellus

RASHP II - Value

Benefit Comparison
Benefit Time Period 01/01/2027 - 12/31/2027

Cost Sharing Expenses

Benefit Name	BluePoint2 Value In Network	BluePoint2 Value Out of Network	BluePoint2 Value Limits	Signature HDHP In Network	Signature HDHP Out of Network	Signature HDHP Limits
Deductible - Single	$0	$750		$1,800	$3,600	
Deductible - Family	$0	$2,250		$3,600	$7,200	
Coinsurance	0%	20%		10%	20%	
Annual Out of Pocket Maximum - Single	$4,200	$4,200		$3,600	$7,200	
Annual Out of Pocket Maximum - Family	$12,600	$12,600		$7,200	$14,400	
Annual Out of Pocket Maximum - Per Person Cap	N/A	N/A		$6,650	$14,400	

Office Visit Cost Shares

Benefit Name	BluePoint2 Value In Network	BluePoint2 Value Out of Network	BluePoint2 Value Limits	Signature HDHP In Network	Signature HDHP Out of Network	Signature HDHP Limits
Cost Share - Primary Care	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	BluePoint2 Value In Network	BluePoint2 Value Out of Network	BluePoint2 Value Limits	Signature HDHP In Network	Signature HDHP Out of Network	Signature HDHP Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			Applies

Who is Covered

Benefit Name	BluePoint2 Value In Network	BluePoint2 Value Out of Network	BluePoint2 Value Limits	Signature HDHP In Network	Signature HDHP Out of Network	Signature HDHP Limits
Domestic Partner Coverage			Not Covered			Not Covered

	BluePoint2 Value			Signature HDHP		
Inpatient Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Services	$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$100 Copayment	20% Coinsurance Subject to Deductible	120 Days per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Days Per year
Physical Rehabilitation	$100 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days Per year
Maternity Care	$100 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Inpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	
Outpatient Facility Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$50 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

	BluePoint2 Value			Signature HDHP		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Infusion Therapy Outpatient	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Substance Use Care	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	20% Coinsurance Subject to $50 Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

	BluePoint2 Value			Signature HDHP		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Infusion Therapy Services	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Telehealth	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - $10 Copayment	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Chiropractic Care	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - $20 Copayment	Not Covered	1 Exam per calendar year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year

Outpatient Facility

Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year

	BluePoint2 Value			Signature HDHP		
Outpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year
Preventive Professional Services Meeting Federal Guidelines*						
Benefit Name	**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	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	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	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

	BluePoint2 Value			Signature HDHP		
Preventive Facility Services Meeting Federal Guidelines*						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% 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**
Prostate Cancer Screening	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	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**
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	$50 Copayment	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$20 Copayment	20% Coinsurance Subject to Deductible		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

	BluePoint2 Value			Signature HDHP		
Additional Benefits						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	10 Visits per contract year
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Diagnoses						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Reimbursement for Travel and Lodging Expenses	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
ER Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	$50 Copayment	$50 Copayment		10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	
Transportation						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	$50 Copayment	$50 Copayment		10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible	

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* 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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

	BluePoint2 Value			Signature HDHP		
Urgent Care						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	$25 Copayment	$25 Copayment		10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Vision						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Pediatric Eye Exams - Routine	$20 Copayment	Not Covered	1 Exam per calendar year	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per calendar year	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$20 Copayment	Not Covered	1 Exam every 2 calendar years	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Covered	Not Covered	$60 Reimbursement every 2 calendar years	Not Covered	Not Covered	Not Covered
Rx Plan						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Rx Plan			$10/$25/$40			$5/$35/$70, $0 Gen for Kids Integrated Rx, Preventive Rx
Rx Benefits						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Days Supply Per Retail Order	30			30		
Days Supply Per Mail Order	90			90		
Copays Per Mail Order Supply	3			2		

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