Excellus

Classic Blue
$2/$10
Benefit Time Period: 01/01/2027 - 12/31/2027

RASHP I

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$100	$100	
Deductible - Family	$300	$300	
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	20%	20%	
Coinsurance Max - Single	$600	$600	
Coinsurance Max - Two Person	$1,200	$1,200	
Coinsurance Max - Family	$1,800	$1,800	
Annual Out of Pocket Maximum - Single	$6,350	$6,350	
Annual Out of Pocket Maximum - Family	$12,700	$12,700	
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% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	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			Yes

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	Covered in Full	120 Days per confinement
Mental Health Care	Covered in Full	Covered in Full	120 Days per confinement
Substance Use Detoxification	Covered in Full	Covered in Full	120 Days per confinement
Skilled Nursing Facility	Covered in Full	Covered in Full	100 Days per calendar year
Physical Rehabilitation	Covered in Full	Covered in Full	30 Days per calendar year
Maternity Care	Covered in Full	Covered in Full	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	Covered in Full	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	Covered in Full	
Diagnostic X-ray	Covered in Full	Covered in Full	
Diagnostic Laboratory and Pathology	Covered in Full	Covered in Full	
Radiation Therapy	Covered in Full	Covered in Full	
Chemotherapy	Covered in Full	Covered in Full	
Lung Cancer Screening Outpatient			
Infusion Therapy Outpatient	Covered in Full	Covered in Full	
Dialysis	Covered in Full	Covered in Full	
Mental Health Care	Covered in Full	Covered in Full	Includes Partial Hospitalization
Substance Use Care	Covered in Full	Covered in Full	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Covered in Full	60 Visits per calendar year
Home Infusion Therapy	Covered in Full	Covered in Full	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	Covered in Full	
Diagnostic X-ray	PCP/Specialist - Covered in Full	Covered in Full	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	Covered in Full	
Radiation Therapy	PCP/Specialist - Covered in Full	Covered in Full	
Chemotherapy	PCP/Specialist - Covered in Full	Covered in Full	
Lung Cancer Screening Services			
Infusion Therapy Services	PCP/Specialist - Covered in Full	Covered in Full	
Dialysis	PCP/Specialist - Covered in Full	Covered in Full	
Mental Health Care	PCP/Specialist - Covered in Full	Covered in Full	
Maternity Care	PCP/Specialist - Covered in Full	Covered in Full	
Telehealth	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 20% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Teledermatology	PCP - 20% Coinsurance Specialist -		
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Speech Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

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	Covered in Full	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	Covered in Full	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	Covered in Full	
Mammography Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	
Mammography Screening Facility	Covered in Full	Covered in Full	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	
Bone Density Screening Facility	Covered in Full	Covered in Full	

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 - Covered in Full	Covered in Full	
Mammography Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	Covered in Full	

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	Covered in Full	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	
Bone Density Screening Facility	Covered in Full	Covered in Full	

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 - Covered in Full	Covered in Full	
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	Covered in Full	
Diabetic Equipment	PCP/Specialist - Covered in Full	Covered in Full	
Durable Medical Equipment (DME)	PCP/Specialist - 50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 50% Coinsurance Subject to Deductible	50% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance	10 Visits Per Contract 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	Covered in Full	Covered in Full	

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Covered in Full	Covered in Full	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full	Covered in Full	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$2/$10

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.