Excellus

RASHP II

Benefit Comparison
Benefit Time Period 01/01/2024 - 12/31/2024

Cost Sharing Expenses

Benefit Name	HDHP $1800 In Network	HDHP $1800 Out of Network	HDHP $1800 Limits	HDHP $6350 In Network	HDHP $6350 Out of Network	HDHP $6350 Limits
Deductible - Single	$1,800	$3,600		$6,350	$12,700	
Deductible - Family	$3,600	$7,200		$12,700	$25,400	
Coinsurance	10%	20%		0%	0%	
Annual Out of Pocket Maximum - Single	$3,600	$7,200		$6,350	$12,700	
Annual Out of Pocket Maximum - Family	$7,200	$14,400		$12,700	$25,400	
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$14,400		$6,650	$25,400	

Office Visit Cost Shares

Benefit Name	HDHP $1800 In Network	HDHP $1800 Out of Network	HDHP $1800 Limits	HDHP $6350 In Network	HDHP $6350 Out of Network	HDHP $6350 Limits
Cost Share - Primary Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Cost Share - Specialist	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	N/A	N/A		N/A	N/A	

Plan Limits

Benefit Name	HDHP $1800 In Network	HDHP $1800 Out of Network	HDHP $1800 Limits	HDHP $6350 In Network	HDHP $6350 Out of Network	HDHP $6350 Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies			Applies

	HDHP $1800			HDHP $6350		
Who is Covered						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Domestic Partner Coverage			Not Covered			Not Covered
Inpatient Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Substance Use Detoxification	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Days Per year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	60 Days Per year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% 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 - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - 10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $6,350 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	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic X-ray	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

	HDHP $1800			HDHP $6350		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Radiation Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Chemotherapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Substance Use Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Home Infusion Therapy	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

	HDHP $1800			HDHP $6350		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Radiation Therapy	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% 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	
Dialysis	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Telehealth	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - 10% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - 0% Coinsurance Subject to Deductible	Not Covered	
Chiropractic Care	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year	PCP / Specialist - 0% Coinsurance Subject to Deductible	0% 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	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per contract year

	HDHP $1800			HDHP $6350		
Outpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per contract year
Occupational Rehabilitation	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	45 Visits per contract year	PCP / Specialist - 0% Coinsurance Subject to Deductible	0% 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	20% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	

	HDHP $1800			HDHP $6350		
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		Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	0% 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 - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% 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	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Facility	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

	HDHP $1800			HDHP $6350		
Additional Benefits						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		PCP / Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	10 Visits per contract year	PCP / Specialist - 0% Coinsurance Subject to Deductible	0% 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	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $6,350 Deductible	
Transportation						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to $1,800 Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $6,350 Deductible	
Urgent Care						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

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

	HDHP $1800			HDHP $6350		
Vision						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Pediatric Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	10% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	1 Exam per contract year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Rx Plan						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Rx Plan			$5/$35/$70, $0 Gen for Kids Integrated Rx, Preventive Rx			Covered in full 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	2			2		

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