

**RASHP II - Extended**

## General Information

### Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$250	
Deductible - Family	\$0	\$750	Each individual does not exceed the single deductible.
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 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.

### Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$5 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$10 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	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	120 Days per year 360 Days per lifetime. Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

## Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	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	Covered in Full	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance Subject to Deductible	\$5 PCP/\$10 Specialist Copay for Injectable Chemo Drugs
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	\$5 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies
Substance Use Care	\$5 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 - \$5 Copayment Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	\$5 PCP/\$10 Specialist Copay for Injectable Chemo Drugs
Infusion Therapy	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 - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$5 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization. NYS Mental Health and Substance Use Disorder (SUD) Provision Applies
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	NYS Maternal Depression Screening Mandate Applies.
Telehealth	PCP - \$5 Copayment Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - \$5 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.
Chiropractic Care	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP - \$5 Copayment Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP - \$5 Copayment Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - \$10 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	\$10 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	\$10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	\$10 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 - \$10 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 - \$10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	PCP/Specialist - \$10 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	
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 - \$5 Copayment Specialist - \$10 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 - \$10 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - \$10 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	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$10 Copayment	20% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - \$5 Copayment	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 - \$5 Copayment	20% Coinsurance Subject to Deductible	
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 Limits are combined INN and OON.
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	\$25 Copayment	\$25 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	\$10 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per calendar year
Adult Eye Exams - Routine	\$10 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			\$5/\$15/\$30

### 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.