Excellus

Classic Blue Secure

50% coin acute, $2/$7/$7 Maint

Benefit Time Period: 01/01/2025 - 12/31/2025

RASHP I

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$0	
Deductible - Family	$0	$0	
Coinsurance	N/A	N/A	
Coinsurance Max - Single	N/A	N/A	
Coinsurance Max - Two Person	N/A	N/A	
Coinsurance Max - Family	N/A	N/A	
Annual Out of Pocket Maximum - Single	$0	$0	
Annual Out of Pocket Maximum - Family	$0	$0	

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	Covers Med B D/C	Covers Med B D/C	
Cost Share - Specialist	Covers Med B D/C	Covers Med B D/C	
Cost Share - Sick Kids	N/A	N/A	

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			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	
Mental Health Care	Equal Med Sup	Equal Med Sup	
Substance Use Detoxification	Equal Med Sup	Equal Med Sup	
Skilled Nursing Facility	Covers Med A D/C	Covers Med A D/C	
Physical Rehabilitation	Not Covered	Not Covered	
Maternity Care	Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	Covers Med A Ded, Daily Copays, Lifetime Reserve Copays	
Anesthesia	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covers Med B D/C	Covers Med B D/C	
Diagnostic X-ray	Cover Med B Copay	Cover Med B Copay	
Diagnostic Laboratory and Pathology	Not Covered	Not Covered	Not Covered
Radiation Therapy	Covers Med B D/C	Covers Med B D/C	
Chemotherapy	Covers Med B D/C	Covers Med B D/C	
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.
Dialysis	Covers Med B D/C	Covers Med B D/C	
Mental Health Care	Equal Med Sup	Equal Med Sup	Includes Partial Hospitalization
Substance Use Care	Equal Med Sup	Equal Med Sup	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covers Med B D/C	N/A	
Home Infusion Therapy	Covers Med B D/C	N/A	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	Covers Med B D/C	Covers Med B D/C	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Diagnostic X-ray	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Radiation Therapy	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Chemotherapy	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
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 - Covers Med B D/C	Covers Med B D/C	
Mental Health Care	PCP/Specialist - Equal Med Sup	Equal Med Sup	
Maternity Care	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Telehealth	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
TeleMedicine Program	PCP/Specialist - Covers Med B D/C	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.
Chiropractic Care	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Allergy Testing	PCP/Specialist - Not Covered	Not Covered	Not Covered
Allergy Treatment Including Serum	PCP/Specialist - Not Covered	Not Covered	Not Covered
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	Covers Med B D/C	Covers Med B D/C	
Occupational Rehabilitation	Covers Med B D/C	Covers Med B D/C	
Speech Rehabilitation	Covers Med B D/C	Covers Med B D/C	

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Occupational Rehabilitation	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Speech Rehabilitation	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	

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	Equal Med Sup	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Not Covered	Not Covered
Routine GYN Visit	PCP/Specialist - Covered in Full	Covers Med B D/C	
Pre/Post-Natal Care	PCP/Specialist - Equal Med Sup	Covers Med B D/C	
Mammography Screening Professional	PCP/Specialist - Covered in Full	N/A	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	N/A	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	N/A	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covers Med B D/C	Covers Med B D/C	
Mammography Screening Facility	Covered in Full	N/A	
Colonoscopy Screening Facility	Covered in Full	N/A	
Bone Density Screening Facility	Covered in Full	N/A	

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	Covers Med B D/C	
Mammography Screening Professional	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	Not Covered
Colonoscopy Screening Professional	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Bone Density Screening Professional	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	

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	Cover Med B Copay	Cover Med B Copay	
Colonoscopy Screening Facility	Covers Med B D/C	Covers Med B D/C	
Bone Density Screening Facility	Cover Med B Copay	Cover Med B Copay	

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 - Covers Med B D/C	Covers Med B D/C	
Treatment of Diabetes - Insulin			
Diabetic Equipment	PCP/Specialist - Covers Med B D/C	Covers Med B D/C	
Durable Medical Equipment (DME)	PCP/Specialist - Not Covered	Not Covered	
Medical Supplies	PCP/Specialist - Not Covered	Not Covered	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Covered in Full	Covered in Full	Must be medically necessary

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	Covers Med B Copay	Covers Med B Copay	

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Covers Med B D/C	Covers Med B D/C	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covers Med B D/C	Covers Med B D/C	

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			50% coin acute, $2/$7/$7 Maint

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.