Excellus

# Comparison of benefits for RCSD

2024

| type of care/plan features | Core Plan Coverage* | Enhanced Plan Coverage* | SimplyBlue Copay/Deductible Coverage* |
|---|---|---|---|
| **Plan features** | | | |
| • Primary Care Physician (PCP) | • Not required | • Not required | • Not required |
| • Referrals | • Not required | • Not required | • Not required |
| • Out of network benefits | • Not covered | • Not covered | • Not covered |
| • Out of area benefits | • Coverage provided worldwide through the BlueCard® program. | • Coverage provided worldwide through the BlueCard® program. | • Coverage provided worldwide through the BlueCard® program. |
| • Student/Dependent coverage | • Qualified dependents and students are covered to age 26. | • Qualified dependents and students are covered to age 26. | • Qualified dependents and students are covered to age 26. |
| **Plan cost-sharing highlights** | | | |
| • Office visit copay (Primary Care Physician) | • $20 copay | • $15 copay | • $25 copay subject to deductible |
| • Office visit copay (Specialist) | • $40 copay | • $15 copay | • $40 copay subject to deductible |
| • Coinsurance | • 20%; Coinsurance Maximum: $750 individual/$2250 family | • None | • None |
| • Deductible | • $250 individual/$750 family | • None | • $600 individual/$1200 family |
| • Out of pocket maximum | • $6350 individual/$12700 family | • $6350 individual/$12700 family | • $4000 individual/$8000 family |
| • Lifetime maximum | • None | • None | • None |
| **Preventive Health Care Services** | | | |
| • Well child visits | • Covered in full | • Covered in full | • Covered in full |
| • Adult routine physical exams | • Covered in full for 1 exam per year according to national guidelines | • Covered in full for 1 exam per year according to national guidelines | • Covered in full for 1 exam per year according to national guidelines |
| • Adult immunizations | • Covered in full | • Covered in full | • Covered in full |
| • Mammography | • Covered in full | • Covered in full | • Covered in full |
| • Pap smear | • Covered in full | • Covered in full | • Covered in full |
| • Routine GYN exam | • Covered in full | • Covered in full | • Covered in full |
| • Prostate cancer screening | • $20 copay per visit with PCP, $40 copay with specialist | • $15 copay | • Covered in Full |
| • Routine vision | • $20 copay for one routine eye exam every year. $60 eyewear allowance every year. | • $15 copay for one routine exam per year; $100 eyewear allowance available per year | • Not Covered |
| • Colonoscopy | • Preventive covered in full | • Preventive covered in full | • Preventive covered in full |
| **Physician Office Services** | | | |
| • Diagnostic office visits | • $20 copay per visit with PCP, $40 copay per visits with specialist | • $15 copay per visit, $0 for children to age 19 for PCP | • $25 copay subject to deductible per visit, $0 subject for children to age 19 for PCP |
| • Diagnostic x-rays | • $40 copay per visit. Precertification applies to MRI, PET and CAT scans. | • $15 copay. Precertification applies to MRI, PET and CAT scans. | • $40 copay subject to deductible. Precertification applies to MRI, PET and CAT scans. |

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|---|---|---|---|
| • Diagnostic laboratory and pathology | • $20 copay per visit | • Covered in full | • $40 copay subject to deductible. |
| • Allergy tests | • $20 copay per visit | • $15 copay per visit | • $40 copay subject to deductible. |
| • Allergy injections | • $20 copay per visit | • $15 copay per visit | • $40 copay subject to deductible. |
| • Chemotherapy | • $40 copay per visit | • Covered in full | • $40 copay subject to deductible. |
| • Radiation therapy | • $40 copay per visit | • Covered in full | • $40 copay subject to deductible. |
| • Second Medical Opinion | • $40 copay per visit | • $15 copay per visit | • $40 copay subject to deductible. |
| • Sick Child Visits | • $20 copay per visit with PCP, $40 copay with specialist | • $0 to age 19 | • $0 to age 19 |
| **Maternity Services** | | | |
| • Prenatal care | • Covered in full | • Covered in full | • $40 copay subject to deductible. |
| • Hospital care for mom (including delivery) | • Covered at 80%, subject to the deductible | • Covered in full | • $1000 copay subject to deductible. |
| • Newborn nursery care | • Covered at 80%, subject to the deductible | • Covered in full | • Covered in full |
| **Prescription Drug** | | | |
| • Short-term and maintenance drugs | • $10/$30/$50 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 2 copays for 90 day supply | • $5/$20/$35 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 1 copay for 90 day supply | • $10/$35/$70 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 1 copay for 90 day supply |
| **Inpatient Hospital Benefits** | | | |
| • Hospital benefits | • Covered at 80%, subject to the deductible. Precertification applies. | • Covered in full for unlimited days. Precertification applies. | • $1000 copay subject to deductible. |
| • Physician visits in the hospital | • Covered at 80%, subject to the deductible | • Covered in full | • $25 copay subject to deductible. |
| • Inpatient physical rehabilitation | • Covered at 80%, subject to the deductible for up to 60 days per year. Precertification applies. | • Covered in full for up to 60 days per year | • $1000 copay subject to deductible. |
| • Surgery | • Covered at 80%, subject to the deductible or $100 copay | • Covered in full | • $1000 copay subject to deductible. |
| • Anesthesia | • Covered at 80%, subject to the deductible | • Covered in full | • Covered in full subject to deductible |
| **Emergency Care** | | | |
| • Emergency room care | • $50 copay per visit, unless admitted within 24 hours | • $50 copay per visit, unless admitted within 24 hours | • $150 copay per visit subject to deductible, unless admitted within 24 hours |
| • Freestanding urgent care center | • $25 copay per visit | • $25 copay per visit | • $40 copay subject to deductible |
| • Ambulance | • $50 copay | • $15 copay | • $150 copay subject to deductible |
| **Outpatient Hospital Benefits** | | | |
| • Diagnostic x-rays | • $40 copay per visit. Precertification applies to MRI, PET and CAT scans. | • $15 copay per visit. Precertification applies to MRI, PET and CAT scans. | • $40 copay subject to deductible |
| • Diagnostic laboratory and pathology | • $20 copay per visit | • Covered in full | • $40 copay subject to deductible |
| • Surgical care | • Covered at 80%, subject to the deductible | • $15 copay | • $100 copay subject to deductible |

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|---|---|---|---|
| • Chemotherapy | • $40 copay per visit | • Covered in full | • $25 copay subject to deductible |
| • Pulmonary Rehabilitation | • $40 copay per visit | • $15 copay per visit | • $40 copay subject to deductible |
| • Hemodialysis | • Covered at 80%, subject to the deductible | • Covered in full | • $40 copay subject to deductible |
| • Radiation therapy | • $40 copay per visit | • Covered in full | • $40 copay subject to deductible |
| **Mental Health and Chemical Dependence** | | | |
| • Inpatient mental health care | • Covered at 80%, subject to the deductible. Precertification applies. | • Covered in full for unlimited days. Precertification applies. | • $1000 copay subject to deductible. |
| • Outpatient mental health care | • $40 copay. Services can be provided in an outpatient facility or in a provider office. | • $15 copay. Services can be provided in an outpatient facility or in a provider office. | • $40 copay subject to deductible |
| • Inpatient chemical dependence | • Covered at 80%, subject to the deductible. Precertification applies. | • Covered in full for unlimited days. Precertification applies. | • Covered in full for unlimited days. Precertification applies. |
| • Outpatient chemical dependence | • $40 copay | • $15 copay per visit | • $15 copay per visit |
| **Other Services** | | | |
| • Diabetic insulin and supplies | • $20 copay for up to a 30 day supply | • $15 Copay | • $25 copay subject to deductible |
| • Skilled nursing facility | • Covered at 80%, subject to the deductible for up to 120 days per year, 360 day lifetime max. Precertification applies. | • Covered in full for up to 120 days per year, 360 day lifetime max. Precertification applies. | • $1000 copay subject to deductible. |
| • Home Care | • $20 per day, 40 visits per year. Precertification applies. | • Covered in full for unlimited visits. Precertification applies. | • $25 copay subject to deductible |
| • Hospice | • Covered in full for unlimited days. | • Covered in full for unlimited days | • 0% coinsurance subject to deductible |
| • Outpatient therapy | • $40 copay per visit for a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy | • $15 copay for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy | • $40 copay subject to deductible for up to a combined total of 45 visits per year for physical, speech, occupational and respiratory therapy |
| • Durable medical equipment and supplies | • Covered at 50%. Precertification applies. | • Covered at 80%. Precertification applies. | • Covered at 80% after deductible. Precertification applies. |
| • External prosthetics and orthotics | • Covered at 50%, subject to the deductible | • Covered at 80% | • Covered at 80% |
| • Chiropractic | • $20 copay per visit | • $15 copay per visit | • $25 copay subject to deductible |
| • Acupuncture | • Covered at 50% for up to 10 visits per year | • Covered at 50% for up to 10 visits per year | • Not Covered |
| • Dental | • Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | • Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly | • Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly |
| • Hearing | • $20 copay for diagnostic exam, no coverage for routine exams. Hearing Aids covered up to $2,000 per year | • $15 copay for diagnostic exam, no coverage for routine exams. Hearing Aids covered up to $2,000 per year | • $40 copay for diagnostic exam, no coverage for routine exams. Hearing Aids not covered. |
| • Private Duty Nursing | • Not Covered | • Not Covered | • Not Covered |
| • Pre-admission testing | • Covered in full | • Covered in full | • Covered in full |