CLASSIC BLUE TRADITIONAL
RASHP Benefit Summary
(Under 65 - No Medicare)

Benefit Type	Benefit description (All benefits and limitations apply to both In-Network & Out of Network services unless noted.)
WHO IS COVERED	
Tiers • Individual • Family	Single Family
Dependent/Student Coverage	26/26
Domestic Partner	Not Covered
MEDICAL NECESSITY	
Pre-Certification	The following services require Pre-certification: • Organ Transplants • Non-mandated Reproductive Procedures (IVF,GIFT,ZIFT); when rider is selected If the services above are not pre-certified, than a 50% or $500 (whichever is less) Penalty will apply.
COST SHARING EXPENSES	
Deductible Standard: Family is an aggregate of all family members combined.	$100 Single/$300 Family Deductible does not apply to prescription drugs or to Institutional billed services covered under Basic Hospital coverage Institutional includes – Inpatient Hospital, Inpatient Mental, Inpatient Chemical Dependency, Inpatient Detox, Inpatient Physical Rehab, Skilled Nursing Facility. Home Care is excluded.
Deductible 4th quarter calendar year carry-over	Applies
Copayment	Where applicable
Coinsurance	20%; Coinsurance Maximum: $600 Single/$1,800 Family
Annual Out-of-Pocket Maximum (Aggregate Family OOP Max: Any combination of individuals can meet the family OOP Max. However, no one person shall exceed the individual OOP Max)	$6350 Single/$12700 Family Annual Out-of-Pocket Maximum includes Deductible, Coinsurance, and Copays.
Lifetime Benefit Maximum	None
HOSPITAL INPATIENT SERVICES	
Inpatient Hospital Services	Covered in full for up to 120 days After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Observation Stay	Cost sharing equal to Inpatient Hospital Services After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Mental Health Care State Mandate for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is inclusive with Inpatient Hospital Services. After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins

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Skilled Nursing Facility	Covered in full for up to 100 days After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins.
Inpatient Physical Rehabilitation	Covered in full up to 30 days per calendar year. After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins.
Substance Use Detoxification, Rehabilitation, & Residential Care Essential Health Benefit	Coverage is equal to Inpatient Hospital Services. After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Maternity Care	Covered in Full
Routine Newborn Nursery Care	Covered in Full
Internal Prosthetics	Benefit inclusive to Inpatient Hospital Services After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins.
HOSPITAL OUTPATIENT SERVICES	
Surgical Care including Surgicenters & Freestanding Facilities	Covered in Full
Pre-admission/Pre-Operative Testing	Covered in Full
Diagnostic Imaging, X-ray, CAT, MRI	Covered in Full
Routine Imaging, X-ray, Ultrasound	Covered in Full
Diagnostic Laboratory and Pathology	Covered in Full
Routine Laboratory and Pathology	Covered in Full
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Covered in Full
Chemotherapy (excludes drugs dispensed by a pharmacy)	Covered in Full
Dialysis	Covered in Full
Mammogram	Covered in Full
Cervical Cytology (Pap Smear and pelvic exam)	Covered in Full
Mental Health Care Includes Partial Hospitalization Essential Health Benefit	Covered in Full, unlimited visits. After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Substance Use Treatment Essential Health Benefit	Covered in Full, unlimited visits. After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Covered Therapies (Includes physical, speech and occupational therapy combined with professional services)	Subject to Deduct/Coins - Unlimited visits
Pulmonary Rehabilitation Therapy	Covered in Full
Cardiac Rehabilitation	Covered in Full

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Home Care	Covered in Full for up to 60 visits per calendar year After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins for up to 325 visits
Hospice Care (Includes 5 bereavement counseling visits)	Covered in Full for unlimited days
PHYSICIAN SERVICES	
Inpatient Hospital Surgery (Assistant surgeon covered only when medically necessary)	Covered in Full
Outpatient Hospital & Ambulatory Surgery	Covered in Full
Office Surgery	Covered in Full
Covered Therapies (Physical, speech and occupational therapy combined with facility)	Subject to Deduct/Coins for unlimited visits
Anesthesia (Includes Inpatient/Outpatient, Office Visits)	Covered in Full
Additional Surgical Opinion	Covered in Full
Second Medical Opinion	Covered in Full
Normal Pregnancy (Includes coverage for a licensed Midwife)	Covered in Full
Prenatal Care	Covered in Full
Newborn Care	Covered in Full
Complications of Pregnancy and Termination [Including elective termination of pregnancy]	Covered in Full
Delivery Anesthesia	Covered in Full
In-Hospital Physician Visits	Covered in Full for up to 120 days After basic benefits above have exhausted, additional coverage will be payable subject to Deduct/Coins
Physician's Office – Preventive Services	
Routine Physical Examinations	Covered in Full for 1 per calendar year
Well Child Visits and Immunizations	Covered in Full
Adult Immunizations	Covered in Full
Physician's Office - Other Services	
Diagnostic Laboratory and Pathology	Covered in Full
Routine Laboratory and Pathology	Covered in Full
Diagnostic Eye Exams	Subject to Deduct/Coins
Routine Eye Exams	Not covered
Routine Eyewear	Not covered
Diagnostic Hearing Evaluations	Subject to Deduct/Coins

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Routine Hearing Evaluations	Not covered
Hearing Aids	Covered for up to 2 hearing aids per lifetime with no age limit
Diagnostic Office Visits	Subject to Deduct/Coins
Office/Outpatient Consultations	Subject to Deduct/Coins
Diagnostic Imaging Services, X-ray, CAT, MRI, etc.	Covered in Full
Routine Imaging Services, X-ray, Ultrasound, etc.	Covered in Full
Chemotherapy	Covered in Full
Radiation Therapy	Covered in Full
Dialysis	Covered in Full
+Routine Mammogram	Covered in Full
+Routine GYN Cervical Screening (When done in conjunction with routine GYN visit)	Covered in Full
Diagnostic GYN Visits	Subject to Deduct/Coins
Prostate Cancer Screenings	Covered in Full
Allergy Testing and Treatment (Injections are inclusive)	Subject to Deduct/Coins
Allergy Serum	Subject to Deduct/Coins
Mental Health Care	Covered in Full, unlimited visits. After basic benefits above exhausted, additional coverage will be payable subject to Deduct/Coins.
Mental Health Care	Covered in Full for unlimited visits
Substance Use Treatment Essential Health Benefit	Covered in Full, unlimited visits. After basic benefits above exhausted, additional coverage will be payable subject to Deduct/Coins.
Autism Applied Behavior Analysis State Mandate: for physician medical services only.	Covered in Full Limit of $45,000 per contract year combined with Out-of-Network
Chiropractic Care	Subject to Deduct/Coins
Inpatient Consultations	Covered in Full
+Bone Density Testing	Covered in Full
ADDITIONAL BENEFITS	
Treatment of Diabetes, Insulin & Supplies, Education, and DME	**Medical Provider:** Subject to Deduct/Coins **Pharmacy:** Benefit equal to Medical provider
Durable Medical Equipment (DME)	Subject to Deduct/50% coinsurance, unlimited
External Prosthetics/Orthotics i.e. braces and artificial arms, legs, eyes (foot orthotics excluded)	Subject to Deduct/50% coinsurance, unlimited
Medical Supplies	Subject to Deduct and 50% coinsurance, unlimited

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Foot Orthotics	Not Covered
Mastectomy Prosthesis	Covered same as similar services under benefit plan
Autism Assistive Communication Devices (ACD)	Covered in full
Air Ambulance Service	Covered in full *Subject to medical review
Prehospital Emergency Services/Transportation – includes all ground transportation	Covered in full
Contraceptive Drugs & Devices including elective sterilization	In Network: Covered in full generic only, brand not covered; Out of Network: Not Covered
Acupuncture	Covered at 50% coinsurance, limit of 10 visits per year
Private Duty Nursing	Not covered
Prescription Drugs	$2/$10 for 30 day supply, 3 copays for 90 day supply
EMERGENCY SERVICES	
Facility Emergency Room	Covered in full
Freestanding Urgent Care Center	Covered in full
Physician's Hospital Freestanding Urgent Care Visit	Covered in full
Physician's Hospital Emergency Room Visit	Covered in full
Organ and Bone Marrow Transplants (Pre-cert required)	Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit, etc.

+This benefit is impacted by the Preventive Care requirements included in the Patient Protections and Affordable Care Act.
In accordance with the PPACA preventive care regulations, full coverage (no cost share) will be applied for those services meeting the requirements as outlined in Grade A and B Recommendations of the United States Preventive Services Task Force."

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. Preventive Services coverage required by the Federal 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 Federal Patient Protection and Affordable Care Act requirements.