Excellus

Excellus BluePPO

Drug Coverage Excluded

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

Rochester Institute of Technology

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$650	$650	
Deductible - Family	$1,950	$1,950	Each individual does not exceed the single deductible.
Coinsurance	20%	30%	
Annual Out of Pocket Maximum - Single	$2,800	$4,200	All cost shares will accumulate to the OOP Max (Deductibles, Coinsurance and Copays, including Rx's adjudicated under the Medical Plan) accumulate to Medical OOP max. See RX OOP Max
Annual Out of Pocket Maximum - Family	$8,400	$12,600	All cost shares will accumulate to the OOP Max (Deductibles, Coinsurance and Copays, including Rx's adjudicated under the Medical Plan) accumulate to Medical OOP max. See RX OOP Max

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$20 Copayment	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	$20 Copayment	30% 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			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	120 Days per year Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	30% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% 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	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive in Primary Service	Inclusive in Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	$20 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$20 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	Limits are combined INN and OON.

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance	30% 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/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive in Primary Service	Inclusive in Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $10 Copayment	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 - $20 Copayment	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 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	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 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 - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 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	30% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	30% 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	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% 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/Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% 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	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

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 - $20 Copayment	30% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - $20 Copayment	30% 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 - $20 Copayment	30% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year
Private Duty Nursing	Not Covered	Not Covered	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$75 Copayment	$75 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	$75 Copayment	$75 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$30 Copayment	30% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$20 Copayment	30% Coinsurance Subject to Deductible	1 Exam every 2 years Limits are combined INN and OON.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$20 Copayment	30% Coinsurance Subject to Deductible	1 Exam every 2 years Limits are combined INN and OON.
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Annual Out-of-Pocket Maximum	The annual out-of-pocket maximum for prescription drug expenses is $2,550 for individual and 5,100 for two person, family or one parent family.		

Rx Benefits

Benefit Name	Wegmans/Optum RX	Other Retail	Limits and Additional Information
Copayment for Up to 30-Day Supply at Retail	Generic: $15 Brand (preferred): $35 Brand (non preferred): $50	Generic: $17 Brand (preferred): $40 Brand (non preferred): $60	Some medications are not covered, have limits, require prior authorization, or have clinical management requirements.
Copayment for Up to 90-Day Supply Wegmans Retail or Optum Rx Mail Order	Generic: $37.50 Brand (preferred): $87.50 Brand (non preferred): $125.00	Not Available	Refer to the Medical and Prescription Drug Plan Summary on the HR website for more details or visit www.OptumRx.com .

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.