Excellus

Excellus HDHP

Drug Coverage Administered by OptumRx
Benefit Time Period: 01/01/2027 - 12/31/2027

Rochester Institute of Technology

General Information

Medical and Rx Cost Sharing

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible – Single (Medical & Rx Combined)	$3,000	$6,000	
Deductible – Family (Medical & Rx Combined)	$6,000	$12,000	
Deductible Aggregation - Single and Family (Medical & Rx Combined)			The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member. If the family deductible amount exceeds the out of pocket maximum per person cap, the individual cannot contribute more than the out of pocket maximum per person cap amount for the plan year.
Coinsurance	20%	40%	
Annual Out of Pocket Maximum – Single (Medical & Rx Combined)	$6,000	$12,000	Out-of-pocket maximums accumulate Medical and Rx coinsurance, copays and the deductible. Out-of- pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum – Family (Medical & Rx Combined)	$12,000	$24,000	Out-of-pocket maximums accumulate Medical and Rx coinsurance, copays and the deductible. Out-of- pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum – Per Person Cap (Medical & Rx Combined)	$8,700	$24,000	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.
Annual Out of Pocket Maximum Aggregation – Single and Family (Medical & Rx Combined)			The entire Family Annual Out-of-Pocket Maximum must be met before family members receive covered services processed at 100% of the allowable amount for the remainder of the plan year. An individual member covered under a family plan may not exceed the Out-of-Pocket Maximum per person cap amount for that plan year, should the family Out-of-Pocket Maximum level exceed the Out-of-Pocket Maximum Per Person Cap.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% 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	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined in network and out of network
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined in network and out of network
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 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	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Lung Cancer Screening Outpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Cost share applies to licensed services and infusion therapy separately.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% 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 Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	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	20% Coinsurance Subject to Deductible	40% 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	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Cost share applies to licensed services and infusion therapy separately.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	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.
Teledermatology	PCP/Specialist - 20% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate with MDLive.
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined IN and OON

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan 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	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan 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	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

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	40% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% 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 – Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist – Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist – Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% 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	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% 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% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist – Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 Deductible	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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

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 (Administered by OptumRx)

Rx Plan Cost Sharing

Benefit Name	
Annual Rx Deductible	Combined with medical (see page 1)
Annual Out of Pocket Maximum – Single	Combined with medical (see page 1)
Annual Out of Pocket Maximum – Family	Combined with medical (see page 1)

Prescription Copayments

Benefit Name	In Network	Limits and Additional Information
Retail 30-day supply (up to 3 fills)	Tier 1 (Generic Drugs): $30 Tier 2 (Brand Name Formulary Drugs): $80 Tier 3 (Brand Name Non-Formulary Drugs): $150	Copayments apply after the deductible (Medical & Rx combined) has been met. Some medications are not covered, have limits, require prior authorization, or have clinical management requirements. Refer to the Medical and Prescription Drug Plan Summary on the HR website for more details or visit www.OptumRx.com.
Retail 30-day supply (4th fill and after)	Tier 1 (Generic Drugs): $75 Tier 2 (Brand Name Formulary Drugs): $200 Tier 3 (Brand Name Non-Formulary Drugs): $375	
90-day supply (Retail or OptumRx Mail)	Tier 1 (Generic Drugs): $75 Tier 2 (Brand Name Formulary Drugs): $200 Tier 3 (Brand Name Non-Formulary Drugs): $375	

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.



RIT hearing benefits

	In-network	Out-of-network	Limits and additional information
Hearing aids	20% Coinsurance	Not Covered	Limits: $3,000 per person, per ear, every 3 years
Diagnostic hearing evaluations	PCP or Specialist copay	Coinsurance, subject to deductible	See info on RIT Audiology Center
Cochlear processor replacement (external) **See limitations**	0% Coinsurance See limitations	• POS A: 20% Coinsurance • POS B and D: 40% coinsurance, subject to deductible • PPO: 30% Coinsurance	• Limits: $6,000 per ear, every 3 years. In- and out-of-network combined. Out-of-pocket maximums do not include balances over allowable expenses. • There are no in-network manufacturers; however, manufacturers may request a Single Case Agreement (SCA) for in-network benefit consideration. See info on SCA Process.

Excellus | Everybody Benefits

Resources

Single Case Agreement (SCA) process

- **Prior Authorization** is required. The manufacturer should call 1-800-363-4658. Ask them to request a Level 1 authorization. This will start the SCA process.
- **Once the SCA is in place**, the manufacturer will deliver your replacement device.
- **The manufacturer will submit the claim with the SCA to Excellus BlueCross BlueShield** (Excellus BCBS). Excellus BCBS submits payment to the manufacturer, then you will be billed.
- **Cochlear Implants** are devices that are considered an internal prosthetic and are covered in full. The implantation of such devices are considered a surgical procedure and therefore, surgery benefits apply (facility, physician and anesthesia). See other side for external processor information.

RIT Audiology Center

The RIT Audiology Center offers free diagnostic hearing tests and hearing consultations to all regular RIT employees. In addition, they offer hearing aids, ear molds, tubes, domes, batteries, and other accessories for purchase at competitive prices. They also provide help with selection, fitting, adjustment, and troubleshooting of hearing aids, and other assistive listening technology; cochlear implant mapping and troubleshooting. They also serve dependents of employees for a charge. For more information, contact the RIT Audiology Center at **585-475-6473** or via email at **audiology@rit.edu**.

A nonprofit independent licensee of the Blue Cross Blue Shield Association.
B-8790 / 20139-24M



Questions?

If you have questions, please call **Excellus BCBS Customer Care at 1-877-253-4797**.



Find in-network providers at ExcellusBCBS.com, when logged into your Excellus BCBS online account on your desktop or mobile app.

Note: You don't have to be logged in to find a provider but when you are logged in, the system recognizes the plan you have and will only show in-network providers.

Excellus