Excellus

# Excellus HDHP

**Benefit Time Period: 01/01/2026 - 12/31/2026**

**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) *Corrected* | $8,500* | $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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Skilled Nursing Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per plan year<br>Limits are combined INN and OON. |
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per plan year<br>Limits are combined INN and OON. |
| Maternity Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

### Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Anesthesia | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to $3,000 Deductible | |

## 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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Imaging (CT/PET scans, MRIs) | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Infusion Therapy Outpatient | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Cost share applies to licensed services and infusion therapy separately. |
| Dialysis | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Home Infusion Therapy | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Chemotherapy | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Infusion Therapy Services | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Cost share applies to licensed services and infusion therapy separately. |
| Dialysis | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Mental Health Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Maternity Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Telehealth | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - 0% Coinsurance<br>Subject to Deductible | Not Covered | Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and, if applicable, Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions. |
| Teledermatology | Specialist - 20% Coinsurance<br>Subject to Deductible | Not Covered | |
| Chiropractic Care | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Allergy Testing/Treatment including Serum | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Allergy Testing includes injections, scratch and prick tests, desensitization treatments (injections & serums). |
| Adult Hearing Aids | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Limits: $3,000 per person, per ear.<br>Every 3 years. |
| Hearing Evaluations Routine | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 1 Exam per plan year<br>Limits are combined INN and OON. |

# Rehab and Habilitation

## Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Physical Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Speech Rehabilitation | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Visits per plan year<br>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<br>Subject to Deductible | 1 Exam per calendar year |
| Adult Immunizations | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Mammography Screening Facility | Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 40% Coinsurance<br>Subject to Deductible | |
| Bone Density Screening Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |

## Other Benefits

### Additional Benefits

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|---|---|---|
| Cochlear Processor Replacement | 0% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | Limits: $6,000 per ear every 3 years. INN and OON combined. See pages 8 & 9 for additional information. |
| Treatment of Diabetes - Non-Insulin Drugs and Supplies | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Medical Supplies | PCP/Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | |
| Acupuncture | Not Covered | Not Covered | Not Covered |
| Private Duty Nursing | 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<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 20% Coinsurance<br>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<br>Subject to Deductible | 40% Coinsurance<br>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

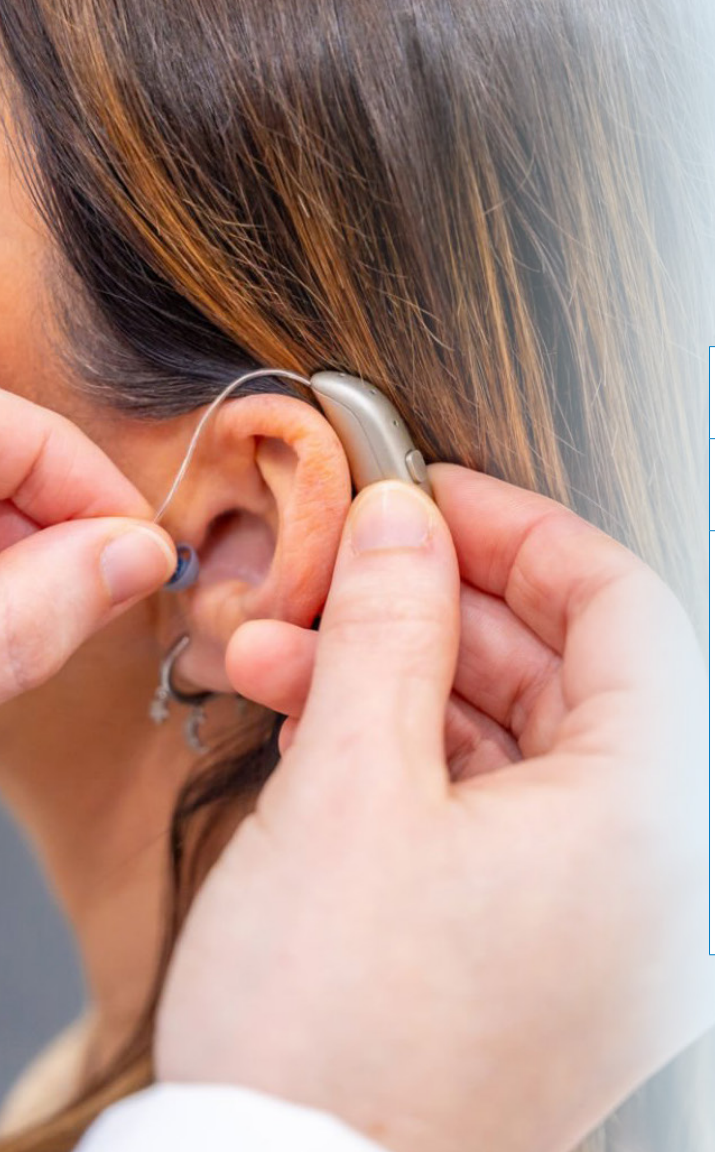
| Benefit Name | Limits and Additional Information |
|---|---|
| Annual Deductible (Single & Family) | Annual Medical and Rx Deductibles are combined. See “Medical and Rx Cost Sharing Expenses” section. |
| Annual Out-of-Pocket Maximum (Single & Family) | Annual Medical and Rx Out-of-Pocket Maximums are combined. See “Medical and Rx Cost Sharing Expenses” section. |

## Prescription Copayments

| Benefit Name | In Network | Limits and Additional Information |
|---|---|---|
| Retail (30-day supply) | Generic: $30<br>Preferred brand: $80<br>Non-preferred brand: $150 | Copayments apply after the annual deductible has been met.<br><br>Some medications are not covered, have limits, require prior authorization, or have clinical management requirements.<br><br>Refer to the Medical and Prescription Drug Plan Summary on the HR website for more details or visit www.OptumRx.com. |
| Retail after 3 fills (30-day supply) | Generic: $62.50<br>Preferred brand: $175<br>Non-preferred brand: $325 | |
| Wegman’s (30-day supply) | Generic: $25<br>Preferred brand: $70<br>Non-preferred brand: $130 | |
| Mail Order and Wegman’s (90-day supply) | Generic: $62.50<br>Preferred brand: $175<br>Non-preferred brand: $325 | |
| Specialty (limited to 30-day supply) | $30 - $150 | |

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<br>• POS B and D: 40% coinsurance, subject to deductible<br>• 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.<br>• 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**.



## 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