Excellus

BluePoint2 – POS A

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

Rochester Institute of Technology

General Information

Medical Cost Sharing Expenses (Rx Out-of-Pocket Maximum details in "Rx Benefits" Section)

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$300	
Deductible - Family	$0	$750	Each individual does not exceed the single deductible.
Deductible Aggregation - Single and Family			Each family member is only subject to the single Deductible and any combination of family members can satisfy the family Deductible as long as one individual does not meet more than the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum – Single	$6,000	$9,000	Annual Out of Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjudicated under Medical Plan).
Annual Out of Pocket Maximum – Family	$12,000	$18,000	Annual Out of Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjudicated under Medical Plan).
Annual Out of Pocket Maximum Aggregation – Single and Family			Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum. Individual

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$45 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$65 Copayment	20% 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	$300 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$300 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$300 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$300 Copayment	20% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	$300 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	$300 Copayment	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to 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	$200 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$65 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance Subject to Deductible	
Lung Cancer Screening Outpatient	Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive in Primary Service	Inclusive in Primary Service	Is inclusive in the Home Care Benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	$65 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$65 Copayment	20% 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	Covered in Full	20% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% 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 - $65 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy Services	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 – Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP - $45 Copayment; Specialist - $65 Copayment	20% 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.
Teledermatology	PCP/Specialist - $65 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate with MDLive.
Chiropractic Care	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $45 Copayment; Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP - $45 Copayment; Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy.
Occupational Rehabilitation	$65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy.
Speech Rehabilitation	$65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy.
Occupational Rehabilitation	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy.
Speech Rehabilitation	PCP/Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of 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	Not Covered	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% 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	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% 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 - $45 Copayment; Specialist - $65 Copayment	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible	

Colonoscopy Screening Professional	PCP/Specialist – Covered in Full	20% Coinsurance Subject to Deductible
Bone Density Screening Professional	PCP/Specialist – Covered in Full	20% 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	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% 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 - $45 Copayment	20% Coinsurance Subject to Deductible	Coverage meets NYS Mandate Requirements. In-Network PCP Copay Applies.
Treatment of Diabetes - Insulin	PCP/Specialist - $45 Copayment	20% Coinsurance Subject to Deductible	Coverage meets NYS Mandate Requirements. In-Network PCP Copay Applies.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year
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	$200 Copayment	$200 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	Covered in Full	Covered in Full	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$75 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$65 Copayment	Not Covered	1 Exam per year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$65 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits (Administered by OptumRx)

Rx Plan Cost Sharing

Benefit Name	In Network	Limits and Additional Information
Annual Out of Pocket Maximum – Single	$2,550	Does not include medical expenses
Annual Out of Pocket Maximum – Family	$5,100	Does not include medical expenses

Prescription Copayments

Benefit Name	In Network	Limits and Additional Information
Retail 30-day supply (up to 3 fills)	Tier 1 (Generic Drugs): $17 Tier 2 (Brand Name Formulary Drugs): $40 Tier 3 (Brand Name Non-Formulary Drugs): $60	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): $42.50 Tier 2 (Brand Name Formulary Drugs): $100 Tier 3 (Brand Name Non-Formulary Drugs): $150	
90-day supply (Retail or OptumRx Mail)	Tier 1 (Generic Drugs): $42.50 Tier 2 (Brand Name Formulary Drugs): $100 Tier 3 (Brand Name Non-Formulary Drugs): $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**	• HDHP: 20% coinsurance subject to deductible • All POS plans: 0% coinsurance, see limitations	• POS A: 20% coinsurance • HDHP, POS B & D: 40% coinsurance, subject to deductible • PPO: 40% coinsurance, subject to deductible	• 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.

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Resources

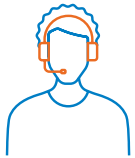
Single Case Agreement (SCA) process

- **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**.

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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.

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