Excellus

BluePoint2 - POS B

Benefit Time Period: 01/01/2024 - 12/31/2024

Rochester Institute of Technology

General Information

Cost Sharing Expenses

Benefit Name	Rochester Regional Health** RRH	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$250	$250	$500	
Deductible - Family	$500	$500	$1,250	
Coinsurance	10%	10%	25%	
Annual Out of Pocket Maximum - Single See Rx Benefits for Out of Pocket Maximum information	$6,450	$6,450	$9,500	Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjuducated under Medical Plan) See RX Out-of-Pocket
Annual Out of Pocket Maximum - Family See Rx Benefits for Out of Pocket Maximum information	$12,900	$12,900	$19,000	Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjuducated under Medical Plan) See RX Out-of-Pocket

Office Visit Cost Shares

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$35 Copayment	$40 Copayment	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are subject to a $20 copay.
Cost Share - Specialist	$40 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are subject to a $20 copay.

Plan Limits

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year				Calendar Year Benefits

Who is Covered

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Covered

Inpatient Services

Inpatient Facility

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	
Mental Health Care	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	
Substance Use Detoxification	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	
Skilled Nursing Facility	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	10% Coinsurance Subject to Deductible	10% Coinsurance Subject to Deductible	25% Coinsurance Subject to Deductible	
Diagnostic X-ray	$55 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are CIF.
Radiation Therapy	$55 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	
Chemotherapy	$55 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive in Primary Service	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	Covered in Full	25% Coinsurance Subject to Deductible	
Mental Health Care	$40 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$40 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Covered in Full	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	Covered in Full	25% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - $55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are subject to a $20 copay.
Diagnostic X-ray	PCP/Specialist - $55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are CIF.
Radiation Therapy	PCP/Specialist - $55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive in Primary Service	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 -$55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $40 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 10% Coinsurance	PCP/Specialist - 10% Coinsurance	25% Coinsurance Subject to Deductible	
Telehealth	PCP -$35 Copayment Specialist -$40 Copayment	PCP - $40 Copayment Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - $10 Copayment	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 - $55 Copayment	PCP/Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP -$40 Copayment Specialist -$55 Copayment	PCP - $40 Copayment Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP -$40 Copayment Specialist -$55 Copayment	PCP - $40 Copayment Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	Includes densensitization treatments (injections & serums)
Hearing Evaluations Routine	Not Covered	Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$55 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy
Occupational Rehabilitation	$55 Copayment	$55 Copayment	25% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of 45 per calendar year of Physical, Speech and Occupational Therapy
Speech Rehabilitation	$55 Copayment	$55 Copayment	25% 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	RRH	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $55 Copayment	PCP/Specialist - $55 Copayment	25% 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 - $55 Copayment	PCP/Specialist - $55 Copayment	25% 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 - $55 Copayment	PCP/Specialist - $55 Copayment	25% 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	RRH	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP -$35 Copayment Specialist -$40 Copayment	PCP - $40 Copayment Specialist - $55 Copayment	25% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are subject to a $20 copay.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	25% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	25% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $40 Copayment	PCP/Specialist - $40 Copayment	25% Coinsurance Subject to Deductible	Coverage meets NYS Mandate Requirements. In-Network PCP Copay Applies.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	25% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits Per Contract Year
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$140 Copayment	$190 Copayment	$190 Copayment	

Transportation

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Covered in Full	Covered in Full	Covered in Full	

Urgent Care

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$60 Copayment	$60 Copayment	25% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	$40 Copayment	$55 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$40 Copayment	$55 Copayment	Not Covered	1 Exam 2 calendar years

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered

Rx Benefits

Benefit Name	Drug Coverage Administered by OptumRx
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	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 Applicable	Refer to the Medical and Prescription Drug Plan Summary on the HR website for more details or visit www.OptumRx.com.

* 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.

**In support of the strategic alliance between RIT and Rochester Regional Health (RRH), medical plan participants pay a slightly lower copay when you obtain the following medical services from certain RRH providers:

- office visit to primary care physician (PCP)
- office visit to specialists
- emergency room visits

The lower copays do not apply to tests, treatments or any other services (e.g., allergy shots, chiropractic services, physical therapy, x-rays, etc.).

To help employees and pre-Medicare retirees locate a physician within the RRH network, use the Find a Doctor search tool found on the RIT Human Resources Benefit page. If you have any questions, you can call the RRH-dedicated help line for RIT at (585)-922-7480/V.

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.