

**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	\$500	\$500	\$1,000	
Deductible - Family	\$1,000	\$1,000	\$2,000	Each individual does not exceed the single deductible maximum.
Coinsurance	20%	20%	40%	
Annual Medical Out of Pocket Maximum - Single	\$6,450	\$6,450	\$9,500	Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjudicated under Medical Plan)
Annual Medical Out of Pocket Maximum - Family	\$12,900	\$12,900	\$19,000	Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copayment. Includes Rx costs adjudicated under Medical Plan)

**Office Visit Cost Shares**

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$35 Copayment	\$40 Copayment	40% 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	40% 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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

## Inpatient Professional Services

Benefit Name	RRH	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% 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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$55 Copayment	\$55 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	Services rendered by the Rochester Regional Family Medicine at RIT are CIF.
Radiation Therapy	\$55 Copayment	\$55 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	\$55 Copayment	\$55 Copayment	40% 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	40% Coinsurance Subject to Deductible	
Mental Health Care	\$40 Copayment	\$55 Copayment	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	\$40 Copayment	\$55 Copayment	40% 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	40% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	Covered in Full	Covered in Full	40% 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	40% 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	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - \$55 Copayment	PCP/Specialist - \$55 Copayment	40% 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	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$40 Copayment	PCP/Specialist - \$55 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 10% Coinsurance Subject to Deductible	PCP/Specialist - 10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP -\$35 Copayment Specialist -\$40 Copayment	PCP - \$40 Copayment Specialist - \$55 Copayment	40% 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	40% 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	40% 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	40% Coinsurance Subject to Deductible	Includes desensitization 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	40% 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	40% 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	40% 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	40% 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	40% 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	40% 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	40% 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	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	40% 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	40% 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	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	40% 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	40% Coinsurance Subject to Deductible	Coverage meets NYS Mandate Requirements. In-Network PCP Copay Applies.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	PCP/Specialist - 20% Coinsurance	40% 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	40% 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 - No prescription drug coverage\*\*\*

### Limits and Additional Information

	***Required coverage under the Affordable Care Act (ACA)
Rx Plan	Generic contraceptives covered with a \$0 copay
	Breast cancer risk-reducing medications (tamoxifen or raloxifene) covered with a \$0 copay - preauthorization is required by the prescribing physician.
	Smoking cessation medications - quantity duration limit of 180 day supply within a 365 day period.

Rx Benefits	Wegmans	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	N/A	N/A		
Days Supply Per Mail Order	N/A	N/A		
Copays Per Mail Order Supply	N/A	N/A		

\* 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.