Excellus

Rochester Institute of Technology

Benefit Comparison
Benefit Time Period 01/01/2026 - 12/31/2026

Cost Sharing Expenses

Benefit Name	HDHP In Network	HDHP Out of Network	HDHP Limits	BluePPO In Network	BluePPO Out of Network	BluePPO Limits
Deductible - Single	$3,000	$6,000		$650	$650	
Deductible - Family	$6,000	$12,000		$1,950	$1,950	
Coinsurance	20%	40%		20%	30%	
Annual Out of Pocket Maximum - Single	$6,000	$12,000		$2,800	$4,200	
Annual Out of Pocket Maximum - Family	$12,000	$24,000		$8,400	$12,600	
Annual Out of Pocket Maximum - Per Person Cap	$8,500	$24,000		N/A	N/A	

Office Visit Cost Shares

Benefit Name	HDHP In Network	HDHP Out of Network	HDHP Limits	BluePPO In Network	BluePPO Out of Network	BluePPO Limits
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$20 Copayment	30% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$20 Copayment	30% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	HDHP In Network	HDHP Out of Network	HDHP Limits	BluePPO In Network	BluePPO Out of Network	BluePPO Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			No

Who is Covered

Benefit Name	HDHP In Network	HDHP Out of Network	HDHP Limits	BluePPO In Network	BluePPO Out of Network	BluePPO Limits
Domestic Partner Coverage			Covered			Covered

	HDHP			BluePPO		
Inpatient Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	120 Days per year
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year	Covered in Full	30% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Inpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Outpatient Facility Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

	HDHP			BluePPO		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Infusion Therapy Outpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$20 Copayment	30% Coinsurance Subject to Deductible	
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$20 Copayment	30% Coinsurance Subject to Deductible	

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance	30% Coinsurance Subject to Deductible	

Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

	HDHP			BluePPO		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Infusion Therapy Services	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Telehealth	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - 0% Coinsurance Subject to Deductible	Not Covered		PCP / Specialist - $10 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year	Not Covered	Not Covered	Not Covered

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year

	HDHP			BluePPO		
Outpatient Professional Services						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Physical Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year
Preventive Professional Services Meeting Federal Guidelines*						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Adult Physical Examination	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per calendar year	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	0% Coinsurance		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

	HDHP			BluePPO		
Preventive Facility Services Meeting Federal Guidelines*						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible	
Preventive services in addition to those required under Federal Guidelines - Professional						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prostate Cancer Screening	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Preventive services in addition to those required under Federal Guidelines - Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	

	HDHP			BluePPO		
Additional Benefits						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	30% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Acupuncture	Not Covered	Not Covered	Not Covered	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
ER Facility						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 Deductible		$75 Copayment	$75 Copayment	
Transportation						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $3,000 Deductible		$75 Copayment	$75 Copayment	

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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

	HDHP			BluePPO		
Urgent Care						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		$30 Copayment	30% Coinsurance Subject to Deductible	
Vision						
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	$20 Copayment	30% Coinsurance Subject to Deductible	1 Exam every 2 years
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	$20 Copayment	30% Coinsurance Subject to Deductible	1 Exam every 2 years
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Rx Benefits (Administered by OptumRx)						
Benefit Name	**Limits and Additional Information**			**In Network**	**Limits and Additional Information**	
Annual Rx Deductible	Annual Medical and Rx Deductibles are combined. See “Cost Sharing Expenses” section.			No Rx Deductible		
Annual Out of Pocket Maximum	Annual Medical and Rx Out-of-Pocket Maximums are combined. See “Cost Sharing Expenses" section.			$2,550 (single) $5,100 (Family)	Does not include medical expenses	
Rx Benefits						
Benefit Name	**In Network**			**In Network**		
Retail (30-day supply)	Generic: $30 Preferred brand: $80 Non-preferred brand: $150			Generic: $15 Preferred brand: $35 Non-preferred brand: $50		
Wegman’s (30-day supply)	Generic: $25 Preferred brand: $70 Non-preferred brand: $130	Specialty (limited to 30-day supply):		Generic: $15 Preferred brand: $35 Non-preferred brand: $50	Specialty (limited to 30-day supply):	
Mail Order and Wegman’s (90-day supply)	Generic: $62.50 Preferred brand: $175 Non-preferred brand: $325	$30- $150		Generic: $37.50 Preferred brand: $87.50 Non-preferred brand: $125	$17- $60	
	Limits and Additional Information Copayments apply after the Rx deductible 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.			**Limits and Additional Information** 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.		

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