Excellus

Rochester Institute of Technology

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

General Information

Cost Sharing Expenses

Benefit Name	POS A In Network	POS A Out of Network	POS A Limits	POS B In Network	POS B Out of Network	POS B Limits	POS D In Network	POS D Out of Network	POS D Limits
Deductible - Single	$0	$300		$500	$1,000		$600	$1,000	
Deductible - Family	$0	$750		$1,000	$2,000		$1,200	$2,000	
Coinsurance	0%	20%		20%	40%		20%	40%	
Annual Out of Pocket Maximum - Single	$5,450	$8,500		$6,450	$9,500		$6,800	$11,500	
Annual Out of Pocket Maximum - Family	$10,900	$17,000		$12,900	$19,000		$13,600	$23,000	

Office Visit Cost Shares

Benefit Name	POS A In Network	POS A Out of Network	POS A Limits	POS B In Network	POS B Out of Network	POS B Limits	POS D In Network	POS D Out of Network	POS D Limits
Cost Share - Primary Care	$35 Copayment	20% Coinsurance Subject to Deductible		$40 Copayment	40% Coinsurance Subject to Deductible		$45 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	$50 Copayment	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	POS A In Network	POS A Out of Network	POS A Limits	POS B In Network	POS B Out of Network	POS B Limits	POS D In Network	POS D Out of Network	POS D Limits
Plan/Calendar Year			Calendar Year Benefits			Calendar Year Benefits			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No			No			No

Who is Covered

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Domestic Partner Coverage			Covered			Covered			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	$200 Copayment	20% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	$200 Copayment	20% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	$200 Copayment	20% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$200 Copayment	20% Coinsurance Subject to Deductible	45 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per year
Physical Rehabilitation	$200 Copayment	20% Coinsurance Subject to Deductible	60 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	$200 Copayment	20% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$140 Copayment	20% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Diagnostic X-ray	$50 Copayment	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Outpatient	Inclusive in Primary Service	Inclusive in Primary Service		Inclusive in Primary Service	Inclusive in Primary Service		Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Mental Health Care	$50 Copayment	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	
Substance Use Care	$50 Copayment	20% Coinsurance Subject to Deductible		$55 Copayment	40% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

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

Hospice Care

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

Outpatient and Office Professional Services

Professional Services

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Office Surgery	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Infusion Therapy Services	PCP / Specialist - Inclusive in Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive in Primary Service	Inclusive in Primary Service		PCP / Specialist - Inclusive in Primary Service	Inclusive in Primary Service	
Dialysis	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 10% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	Specialist - $50 Copayment PCP - $35 Copayment	20% Coinsurance Subject to Deductible		Specialist - $55 Copayment PCP - $40 Copayment	40% Coinsurance Subject to Deductible		Specialist - $60 Copayment PCP - $45 Copayment	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - $10 Copayment	Not Covered		PCP / Specialist - $10 Copayment	Not Covered		PCP / Specialist - $10 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - $50 Copayment PCP - $35 Copayment	20% Coinsurance Subject to Deductible		Specialist - $55 Copayment PCP - $40 Copayment	40% Coinsurance Subject to Deductible		Specialist - $60 Copayment PCP - $45 Copayment	40% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	Specialist - $50 Copayment PCP - $35 Copayment	20% Coinsurance Subject to Deductible		Specialist - $55 Copayment PCP - $40 Copayment	40% Coinsurance Subject to Deductible		Specialist - $60 Copayment PCP - $45 Copayment	40% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

	POS A			POS B			POS D		

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	$55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	$60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $55 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - $60 Copayment	40% Coinsurance Subject to Deductible	45 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% 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**	**In Network**	**Out of Network**	**Limits**
Prostate Cancer Screening	Specialist - $50 Copayment PCP - $35 Copayment	20% Coinsurance Subject to Deductible		Specialist - $55 Copayment PCP - $40 Copayment	40% Coinsurance Subject to Deductible		Specialist - $60 Copayment PCP - $45 Copayment	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP / Specialist - $35 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $40 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $45 Copayment	40% Coinsurance Subject to Deductible	
Treatment of Diabetes - Insulin	PCP / Specialist - $35 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $40 Copayment	40% Coinsurance Subject to Deductible		PCP / Specialist - $45 Copayment	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	40% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to $700 Deductible	10 Visits per year
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

	POS A			POS B			POS D		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	$140 Copayment	$140 Copayment		$190 Copayment	$190 Copayment		$215 Copayment	$215 Copayment	

Transportation

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

Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	$55 Copayment	20% Coinsurance Subject to Deductible		$60 Copayment	40% Coinsurance Subject to Deductible		$65 Copayment	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	$50 Copayment	Not Covered	1 Exam per calendar year	$55 Copayment	Not Covered	1 Exam per calendar year	$60 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$50 Copayment	Not Covered	1 Exam every 2 calendar years	$55 Copayment	Not Covered	1 Exam every 2 calendar years	$60 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Rx Benefits (Administered by OptumRx)

Rx Plan Cost Sharing

Benefit Name	In Network	Limits and Additional Information	In Network	Limits and Additional Information	In Network	Limits and Additional Information
Annual Rx Out of Pocket Maximum	$2,550 (single) $5,100 (Family)	Does not include medical expenses	$2,550 (single) $5,100 (Family)	Does not include medical expenses	Annual Rx Deductible: $1,250 per person $2,650 (single) $5,300 (Family)	Does not include medical expenses

Prescription Copayments

Benefit Name	POS A In Network		POS B In Network		POS D In Network	
Retail (30-day supply)	Generic: $17 Preferred brand: $40 Non-preferred brand: $60		Generic: $17 Preferred brand: $40 Non-preferred brand: $60		Generic: $30 Preferred brand: $80 Non-preferred brand: $150	
Wegman's (30-day supply)	Generic: $15 Preferred brand: $35 Non-preferred brand: $50	Specialty (limited to 30-day supply):	Generic: $15 Preferred brand: $35 Non-preferred brand: $50	Specialty (limited to 30-day supply):	Generic: $25 Preferred brand: $70 Non-preferred brand: $130	Specialty (limited to 30-day supply):
Mail Order and Wegman's (90-day supply)	Generic: $37.50 Preferred brand: $87.50 Non-preferred brand: $125	$17- $60	Generic: $37.50 Preferred brand: $87.50 Non-preferred brand: $125	$17- $60	Generic: $62.50 Preferred brand: $175 Non-preferred brand: $325	$30- $150

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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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.