

ROCHESTER INSTITUTE OF TECHNOLOGY
Blue PPO (Pre-Medicare)
2009 Benefit Summary

The Blue PPO is available only to those who live outside the Rochester Area

GENERAL INFORMATION

Contacting the Carrier	Voice: (800) 847-1200 and (585) 325-3630; TTY: (585) 454-2845 Website: www.excellusbcbs.com
Coverage Effective Dates	<p>New Employees: Coverage is effective the first of the month after date of hire: if date of hire is the first of the month, coverage will be effective on date of hire.</p> <p>Retirees: Coverage is effective the date you move out of the Rochester Area.</p> <p>Current employees: Coverage changes will be effective the date of the event (e.g., marriage - coverage effective date of marriage).</p> <p>Open Enrollment changes are effective January 1.</p>
Premium Payments	<p>Employee contributions for coverage are made 24 times per year for semi-monthly (salaried) and 26 times per year for bi-weekly (hourly) employees. Contributions are made on a before-tax basis - they are not subject to federal, FICA (Medicare and Social Security), and state taxes.</p> <p>Retiree contributions for coverage are made monthly by check to RIT's administrator.</p>
Dependent Coverage	Qualified dependents are covered to age 26
Referral to Specialists	No referral required
Deductible and Co-Insurance	<p>Annual deductible of \$500 per member, \$1,500 per family per calendar year (applies to both participating and non-participating providers). After the deductible has been paid, the plan pays:</p> <ul style="list-style-type: none">• 80% of covered services for <u>participating providers</u>, and• 70% of covered services for <u>non-participating providers</u>. <p>You pay the remaining portion of co-insurance for covered services, until you reach the Annual Out-of-Pocket Maximum (see below); then the plan pays 100% of most covered services for the remainder of the calendar year.</p>
Deductible Carry-Over	Yes; if you have not met your deductible during the calendar year and have claims for expenses during the last calendar quarter (October-December), the last quarter's expenses will be applied toward the next calendar year's deductible.
Annual Out-of-Pocket Maximum	You annual out-of-pocket maximum is \$1,250 per member (\$500 deductible plus \$750 co-insurance), with a family maximum of \$3,750 (\$1,500 deductible plus \$2,250 co-insurance) (applies to both participating and non-participating providers). After this annual out of pocket maximum has been reached, the plan pays 100% of most covered services for the remainder of the calendar year.

Termination of Coverage At termination of employment, coverage ends the last day of the month in which the employee terminates. When coverage ends, an individual may elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for up to 18 months (in some cases, the period of time may be greater than 18 months). In such cases, individuals are responsible for paying the full monthly premium plus a 2% administrative fee, as allowed under federal law. At the end of the COBRA coverage period, an individual may elect to convert coverage to an individual policy directly with the insurance carrier.

At retirement, coverage may continue in the BluePPO retiree plan.

Lifetime Benefit Maximum None for Participating or Non-participating providers.

Pre-Authorization required for all inpatient admissions, home health, infusion therapy, DME over \$200, MRI, CAT scans and PET scans

	<u>Participating</u>	<u>Non-Participating</u>
<u>HOSPITAL INPATIENT SERVICES</u>		
Hospice	Covered at 80%	Covered at 70%, subject to deductible
Hospital Services	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Inpatient Physical Rehabilitation-60 days	Covered in full	Covered at 70%, subject to deductible
Skilled Nursing Facility	Covered at 80%, subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered.	Covered at 70%, subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered.
<u>HOSPITAL OUTPATIENT SERVICES</u>		
Chemotherapy	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Diagnostic Laboratory and Pathology	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible

	<u>Participating</u>	<u>Non-Participating</u>
Diagnostic X-Ray	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Kidney Dialysis	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Pre-admission Testing	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Radiation Therapy	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Routine Cervical Cancer Screening (Pap Smear)	Covered in full	Covered at 70%, subject to deductible
Routine Mammography	Covered in full	Covered at 70%, subject to deductible
Surgical Care	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible

EMERGENCY/URGENT CARE AND OUT OF AREA COVERAGE

Ambulance	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Emergency Care	\$50 per visit unless admitted within 24 hours	\$50 per visit unless admitted within 24 hours
Freestanding Urgent Care	\$25 per visit	Covered at 70%, subject to deductible
Out of Area Coverage	Blue Card	Blue Card

PHYSICIAN SERVICES

Hospital Inpatient

Anesthesia	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Physician Visits	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Surgery	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible

	<u>Participating</u>	<u>Non-Participating</u>
<u>Physician's Office</u>		
Allergy Injections	Covered in full	Covered at 70%, subject to deductible
Allergy Tests	\$15 per visit	Covered at 70%, subject to deductible
Chemotherapy	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Diagnostic Office Visits	\$15 per visit	Covered at 70%, subject to deductible
Eye Exams	\$15 co-payment for routine eye exams, once every 2 years. \$15 co-payment for eye exams associated with disease or injury.	Covered at 70%, subject to deductible.
Eye Wear	\$60 allowance toward the purchase of one pair of eyeglasses or contact lenses through a participating provider once every 2 years. One pair of corrective lenses after cataract surgery covered in full.	\$60 allowance toward the purchase of one pair of eyeglasses or contact lenses once every 2 years. One pair of corrective lenses after cataract surgery covered at 70%, subject to the deductible.
Hearing Aids	Covered for children under age 19. Maximum of \$600 per child every 3 years through participating providers.	Only available from a participating provider
Hearing Evaluations	Routine care not covered. \$15 copay for diagnostic visit.	Routine care not covered. Covered at 70%, subject to deductible for diagnostic visit.
Diagnostic Laboratory and Pathology	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Diagnostic X-ray	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Radiation Therapy	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible

Participating

Non-Participating

Routine Preventive Services

Periodic routine physicals covered, \$15 co-payment per visit, according to National Medical Specialty recommended schedule.

Periodic routine physicals covered at 70%, subject to the deductible, according to National Medical Specialty recommended schedule.

Annual pelvic exams, Pap Smears, and periodic mammograms covered in full.

Annual pelvic exams, Pap Smears, and periodic mammograms covered at 70%, subject to the deductible

Periodic well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics recommended schedule.

Periodic well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics recommended schedule.

Second Surgical Opinion

Covered at 80%, subject to deductible

Covered at 70%, subject to deductible

MATERNITY

Hospital Services

Hospital Charges for Mother

Covered at 80%, subject to deductible

Covered at 70%, subject to deductible

Newborn Nursery Care

Covered at 80%

Covered at 70%, subject to deductible

Physician Charges for Mother

Covered at 80%, subject to deductible

Covered at 70%, subject to deductible

Physician Services

Pre- and Post-natal Care and Delivery

Covered at 80%, subject to deductible

Covered at 70%, subject to deductible

Participating

Non-Participating

PSYCHIATRIC and CHEMICAL DEPENDENCE

Inpatient

Acute Psychiatric	Covered at 80%, subject to deductible for up to 30 days of hospital and physician care per member per calendar year	Covered at 70% subject to deductible for up to 30 days of hospital and physician care per member per calendar year
Chemical Dependence	Covered at 80%, subject to deductible for up to 7 days of hospital and physician care per member per calendar year for detoxification only. Two admissions per lifetime	Covered at 70%, subject to deductible for up to 7 days of hospital and physician care per member per calendar year for detoxification only. Two admissions per lifetime

Outpatient

Acute Psychiatric	Covered at 50%, subject to the deductible for up to 20 visits per member per calendar year	Covered at 50%, subject to the deductible for up to 20 visits per member per calendar year
Chemical Dependence	Covered at 80%, subject to deductible for up to 60 visits per calendar year, 20 of which can be used for family therapy	Covered at 70%, subject to deductible for up to 60 visits per calendar year, 20 of which can be used for family therapy

OTHER SERVICES

Acupuncture Services	Covered at 50% subject to the deductible for up to 10 visits per member per calendar year	Covered at 50% subject to the deductible for up to 10 visits per member per calendar year
Cardiac Rehabilitation	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Chiropractic Services	\$15 co-payment per visit	Covered at 70%, subject to deductible
Dental	Not covered	Not covered
Elective Sterilization	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible

Participating

Non-Participating

Health and Wellness Programs	Member Rewards is your connection to local health resources. Programs featuring massage therapy, biofeedback, nutrition and much more are available, and very affordable. The way you live your life today has a profound effect on your quality of life tomorrow - check out our ever expanding programs and services.	Not applicable
Hearing Aids	\$600 every 3 years for children to 19	Not covered
Home Care	Covered at 80%, subject to \$50 deductible for unlimited visits	Covered at 75%, subject to \$50 deductible for unlimited visits
Occupational Therapy	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year
Respiratory Therapy-	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year
Second Surgical Opinion	\$15 per visit	Covered at 70%, subject to deductible
Physical Therapy	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, and speech therapy per member per calendar year	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, and speech therapy per member per calendar year

Prescription Drug Coverage

Prescription Drugs Covered Under Medical Plan

Non-Participating

Not Covered

Participating

Coverage for diabetic oral agents, insulin and diabetic supplies as follows:

30-day supply retail - \$20 per prescription

Injectible Drugs

\$20 co-payment for all physician administered injectible drugs including, but not limited to, chemotherapy agents and injectible contraceptives. The co-payment is on the injectible agent and is in addition to any other co-payment.

The co-payment does not apply to immunizations, vaccinations and allergy serums.

Prescription Drugs Covered Under RIT Rx Prescription Drug Plan

Non-Participating

Only available from participating pharmacies

Participating

Local Pharmacy: Short-term medications can be purchased at the local pharmacy with the 30-day applicable co-payment as show below. You cannot purchase a quantity greater than a 30-day supply at the retail pharmacy. If you take maintenance medications, you will save money if you purchase them through the mail order program.

Under the **Retail Refill Allowance (RRA)** program, if you fill your maintenance medications at the retail pharmacy, you will pay the 90-day mail order co-payment for a 30-day supply beginning with the 4th fill (but no more than the cost of the medication). RRA does not apply to acute medications (e.g., antibiotics) or medications that cannot be filled through mail order (e.g., certain controlled substances).

Mail Order Maintenance: Certain types or categories of medications can be purchased by mail order in up to a 90-day supply for the co-payments shown below.

There are three categories of prescription medication with different co-payment amounts. **NOTE:** the 90-day supply co-payments are for mail order program only.

	RETAIL <u>30-day supply</u>	MAIL ORDER <u>90-day supply</u>
Tier 1: generic drugs	\$10	\$25
Tier 2: formulary brand name drugs	\$25	\$62.50
Tier 3: non-formulary brand name	\$40	\$100

In cases of selected brand name drugs where an FDA-approved generic is available, your benefit will be based on the generic drug's cost. If you or your doctor choose the brand-name drug, you will have to pay the difference, plus any applicable co-payments. If your prescription does not have an approved generic substitute, your benefit will not be affected.

Participating

Non-Participating

Private Duty Nursing	Not covered	Not covered
Prosthetics & Orthopedic Braces and Supports (External)	Standard equipment covered at 80%, subject to the deductible, up to \$15,000 per member per calendar year	Standard equipment covered at 70%, subject to the deductible, up to \$15,000 per member per calendar year
Prosthetics (Internal)	Covered at 80%, subject to deductible	Covered at 70%, subject to deductible
Speech Therapy	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year

ROCHESTER INSTITUTE OF TECHNOLOGY
Medical and Dental Insurance Rates
Calendar Year 2009

Medical Plan	Level of Coverage	Per Pay Period Employee Contribution									
		FULL-TIME SALARY LEVEL 1 <i>(1/1/09 salary < \$35,000)</i>		FULL-TIME SALARY LEVEL 2 <i>(1/1/09 salary => \$35,000)</i>		FULL-TIME SALARY LEVEL 3 <i>(1/1/09 salary < \$74,000)</i>		FULL-TIME SALARY LEVEL 4 <i>(1/1/08 salary => \$111,000)</i>		EXTENDED PART-TIME ALL SALARIES	
		Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)
Blue PPO <i>(those who live outside Rochester area)</i>	Individual	\$71.49	\$65.99	\$82.66	\$76.30	\$86.58	\$79.92	\$89.67	\$82.77	\$126.09	\$116.39
	2 Person	\$169.21	\$156.19	\$182.62	\$168.58	\$186.99	\$172.60	\$191.45	\$176.72	\$280.84	\$259.24
	Family	\$220.06	\$203.13	\$239.88	\$221.43	\$245.71	\$226.81	\$251.41	\$232.07	\$347.27	\$320.56
	One-Parent Fam	\$191.75	\$177.00	\$208.63	\$192.58	\$213.66	\$197.22	\$218.63	\$201.82	\$300.13	\$277.04