ROCHESTER INSTITUTE OF TECHNOLOGY
Blue PPO (Pre-Medicare)
2022 Benefit Summary

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

GENERAL INFORMATION	
Contacting the Carrier	Voice: (877) 253-4797; TTY: 800-421-1220 Website: www.excellusbcbs.com/rit
Coverage Effective Dates	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. Retirees: Coverage is effective the date you move out of the Rochester Area. Current employees: Coverage changes will be effective the date of the event (e.g., marriage – coverage effective date of marriage). Open Enrollment changes are effective January 1.
Termination of Coverage	At termination of employment coverage ends the last day of the month in which the employee terminates. At retirement, coverage may continue in one of the retiree plans. 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 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 Excellus BlueCross BlueShield. Refer to the Medical Care Section of the Employee Benefits Handbook or in the Plan Summary on the HR website for more details
Premium Payments	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. Retiree contributions for coverage are paid monthly to RIT's billing administrator.
Referral to Specialists	No referral required

Deductible, Co-Insurance, Out-of-Pocket Maximum-Medical Plan (Excellus BCBS)	Annual deductible of $650 per member, $650 per person for two person and $1,950 per family per calendar year (applies to both participating and non-participating providers). Once the deductible has been paid, you will pay • 20% of covered services for participating providers, and • 30% of covered services for non-participating providers. ***Participating***: The annual out-of-pocket maximum is $2,300 for individual ($650 deductible plus $1,650 co-insurance), $4,600 for two person ($1,300 deductible plus $3,300 co-insurance), and $6,900 for family ($1,950 deductible plus $4,950 co-insurance). 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. ***Non-Participating***: The annual out-of-pocket maximum is $3,450 for individual, $6,900 for two person, and $10,350 for family. 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. The participating and non-participating maximums are combined.
Deductible Carry-Over-In Network	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.
Pre-Authorization required for all inpatient admissions, home health, infusion therapy, DME over $200, MRI, CAT scans and PET scans	

Services (sorted alphabetically)	Participating	Non-Participating
Acupuncture	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.
Allergy Injections	Covered in full.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Allergy Tests	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Ambulance	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Bone Density Testing-Routine Preventive	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm).	After you pay the deductible, you pay 30% and the Plan pays 70%.

Cardiac Rehabilitation	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Chemical Dependence-Inpatient	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Chemical Dependence-Outpatient	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Chemotherapy	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Chiropractic Services	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Cochlear Implants	Must be medically necessary and prior authorization is required. Covered at 80%, subject to deductible (covered under hospital inpatient and internal prosthetic).	Must be medically necessary and prior authorization is required. Covered at 70%, subject to deductible (covered under hospital inpatient and internal prosthetic).
Cochlear Implants-Replacement of Properly Functioning Processor	The Play pays 80% up to $6,000 every six years.	The Play pays 80% up to $6,000 every six years.
Colonoscopy-Diagnostic	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Colonoscopy-Routine	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm).	After you pay the deductible, you pay 30% and the Plan pays 70%.
Durable Medical Equipment (DME)	You pay 20% and the plan pays 80% for standard equipment when purchased from a participating provider.	After you pay the deductible, you pay 30% and the Plan pays 70% for standard equipment.
Emergency Care	$75 copay per visit unless admitted within 24 hours.	$50 copay per visit unless admitted within 24 hours.
Eye Exams-Diagnostic	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Eye Exams-Routine	$20 copay for routine eye exams, once every 2 years.	After you pay the deductible, you pay 30% and the Plan pays 70%.

Eye Wear	No coverage through medical plan. One pair of corrective lenses after cataract surgery covered in full. There is coverage under RIT's separate Vision Care Plan. Refer to that Plan Summary for details.	No coverage through medical plan. One pair of corrective lenses after cataract surgery covered in full. There is coverage under RIT's separate Vision Care Plan. Refer to that Plan Summary for details.
Health and Wellness Programs	Blue 365 is a national program that gives you exclusive access to information, discounts and savings, making it easier and more affordable to make healthy choices. **Fitness**: save on membership, monthly fees and other services at Gold's Gym®, Curves®, Snap Fitness™ and GlobalFit™. **Nutrition**: Save on programs, products and consultations at eDiets®, Kronos Optimal Health®, Jenny Craig® and NutriSystem®. **Elective Procedures**: save on vision products and service at Davis Vision®, QualSight LASIK®, LasikPlus® and TruVision™. **Hearing aids**: Save on products from Beltone™ and TruHearing. Explore all the health choices at www.excellusbcbs.com/Blue365 for more details.	Not applicable
Hearing Evaluations-Diagnostic	$20 copay per visit.	Covered at 70%, subject to deductible for diagnostic visit.
Hearing Evaluations-Routine	No coverage for routine care.	No coverage for routine care.
Hearing Aids	Plan covers 80%, up to $3,000 per ear every three years. ***NOTE**: RIT's Vision Coverage with VSP includes hearing aid discounts with TruHearing. Click here to learn more*	Only available from a participating provider.
Home Care	Covered at 80%, subject to $50 deductible for unlimited visits.	Covered at 75%, subject to $50 deductible for unlimited visits.
Hospice	Covered at 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Hospital Services-Inpatient	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.

Hospital Pre-Admission Testing	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Laboratory and Pathology	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Mammogram-Diagnostic	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Mammogram-Preventive	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm).	After you pay the deductible, you pay 30% and the Plan pays 70%.
Maternity-Hospital Charges for Mother (including Delivery Room)	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Maternity-Newborn Nursery Care	Covered at 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Maternity-Prenatal and Postpartum Care	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Mental Health-Inpatient	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Mental Health-Outpatient	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
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.
Out of Area Coverage	With BlueCard, you have access to a provider finder 24 hours a day by calling 1-800-810-BLUE (2583).	With BlueCard, you have access to a provider finder 24 hours a day by calling 1-800-810-BLUE (2583).
Pap Smear-Diagnostic	Covered in full. Office visit copay may apply.	After you pay the deductible, you pay 30% and the Plan pays 70%.

Pap Smear-Preventive	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm).	After you pay the deductible, you pay 30% and the Plan pays 70%.
Physician Visit – In Office, Diagnostic (ill or injured	$20 copay per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Physician Visit – In Office, Routine Preventive Services	Adult routine physicals covered in full once per calendar year. Routine semi-annual GYN visits, including Pap Smear covered in full. Routine mammograms, prostate cancer screenings, and bone density testing covered in full. Adult immunizations covered in full, according to American Medical Association guidelines. 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 guidelines.	After you pay the deductible, you pay 30% and the Plan pays 70% for adult routine physicals once per calendar year, for semi-annual GYN visits, including Pap Smear and for adult immunizations, according to American Medical Association guidelines. 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 guidelines.
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 under Medical Plan	Injectible Drugs: $20 copay for all physician administered injectible drugs including, but not limited to, chemotherapy agents and injectible contraceptives. The copay is on the injectible agent and is in addition to any other copay. Prescription drugs administered while in the hospital are covered under the hospitalization coverage. Copay does not apply to immunizations, vaccinations and allergy serums. Prescription drugs administered while in a doctor's office are covered under the medical plan. Prescription drugs administered while in the hospital are covered under the hospitalization coverage.	

Prescription Drug Coverage Information under RIT Prescription Drug Plans (OptumRx)

The prescription drug coverage for medical plans POS A, B, and D, and Blue PPO is provided by OptumRx. There is no prescription drug coverage for POS B No Drug except as indicated in the previous section titled *Prescription Drug Coverage under Medical Plan (Excellus BCBS)*. Prescription drugs administered while in the hospital or doctor's office may be covered under your medical plan.

Copays and days-supply limits are based on the drug tier and where you fill your prescription: Wegmans Pharmacy, other participating retail pharmacy, OptumRx mail pharmacy, or a nonparticipating retail pharmacy. The following rules apply:

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

2. If you fill your prescription at a non-participating pharmacy, you will be required to pay the pharmacy's full charge for your medication at the time you purchase it. You may then submit a claim form to OptumRx to obtain reimbursement. Your total amount paid after reimbursement may be more than it would have been if you had gone to a participating pharmacy.

3. 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.

4. Required coverage under the Affordable Care Act (ACA)
    a. For women, generic contraceptives are covered with a copay of $0. If there is no generic equivalent, the copay is $0 for a brand name contraceptive. The deductible under POS D would not apply if you have a $0 copay. All other plan rules will otherwise apply. Note: If there is a medical reason certified by your physician through the prior authorization process that you are unable to take the generic equivalent, the copay for the brand contraceptive would be $0.
    b. There will be a $0 copay for breast cancer risk-reducing medications (tamoxifen or raloxifene) for patients age 35 and older who have not had a breast cancer diagnosis, who are at increased risk for breast cancer, and who are at low risk for adverse medication effects. In addition to the coverage required by the ACA, this $0 copay also applies to patients age 35 and older who have had a breast cancer diagnosis. To qualify for coverage, preauthorization is required by the prescribing physician. Those covered under POS D do not need to meet the deductible before the $0 copay. The prescribing physician can call 1-800-626-0072 to obtain the preauthorization.
    c. All smoking cessation medications, including over-the-counter nicotine replacement products (e.g., nicotine patch, gum, lozenges), for those over the age of 18 will be covered in full for a quantity duration limit of 180 day supply within a 365 day period, provided there is a written prescription from a physician.

Prescription Drug Coverage under RIT Prescription Drug Plan (OptumRx), cont'd

Prescription Drug Coverage	Blue PPO	
	Wegmans	Other Retail [1]
Annual Deductible (individual/family)	Not Applicable	
Annual Patient Maximum Out-of-Pocket (individual/family)	$2,150/$4,300	
Up to 30-Day Supply at Retail		
Tier 1: Generic	$15.00	$17.00
Tier 2: Brand Name-Formulary (preferred)	$35.00	$40.00
Tier 3: Brand Name-Non-Formulary (non-preferred)	$50.00	$60.00
Up to 90-Day Supply at Wegmans or OptumRx Mail Order		
Tier 1: Generic	$37.50	Not Available
Tier 2: Brand Name-Formulary (preferred)	$87.50	Not Available
Tier 3: Brand Name-Non-Formulary (non-preferred)	$125.00	Not Available

[1] The non-Wegmans 30-day retail copay applies only for acute medications (e.g., antibiotic), controlled substances and the first three fills of a maintenance medication (e.g., cholesteral lowering). The copay for the 4th fill of a maintenance medication at a non-Wegmans retail pharmacy will be 90-day copay amount.

Private Duty Nursing	Not covered.	Not covered.
Prostate Testing-Routine Preventive	Covered in full	After you pay the deductible, you pay 30% and the Plan pays 70%.
Prosthetics & Orthopedic Braces & 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)	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
Radiology (MRI, CAT, X-Ray)	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
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.
Radiation Therapy	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.
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.
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.
Surgery	After you pay the deductible, you pay 20% and the Plan pays 80%.	After you pay the deductible, you pay 30% and the Plan pays 70%.

Telemedicine with MDLIVE	***NOTE**: this is for telemedicine visits with MDLIVE, not telehealth visits with your own provider.* $10 copay per visit. Telemedicine provides an easy-to-use platform offering the convenience of an in-person doctor visit. A member can call or videoconference with a physician 24/7/365 for an urgent (not life-threatening) condition. MDLIVE providers are available for urgent care needs as well as behavioral health needs. For behavioral health, you can schedule recurring appointments to establish an ongoing relationship with one therapist. You should register in advance of needing services; you can also register your covered family members. **There are four easy ways to register for telemedicine today.** 1. **Web**—Register/Log in at ExcellusBCBS.com/Member 2. **App**—Download the MDLIVE app 3. **Text**—Text EXCELLUS to 635483 4. **Voice**—Call 1-866-692-5045 When registering, you'll provide: • your name • date of birth • address • phone number(s) • Excellus BCBS membership ID# • a unique username and password • the answer to a security question of your choice • the name, address, fax number and phone number of your primary care provider.	N/A
Urgent Care	$30 per visit.	After you pay the deductible, you pay 30% and the Plan pays 70%.

Well Child Visits	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 guidelines.	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 guidelines.

12-Month Deductions

Medical Plan	Level of Coverage	Per Pay Period Employee Contribution											
		FULL-TIME SALARY LEVEL 1* Salary < $46,000		FULL-TIME SALARY LEVEL 2* Salary = $46,000-97,999		FULL-TIME SALARY LEVEL 3* Salary = $98,000-145,999		FULL-TIME SALARY LEVEL 4* Salary => $146,000		PART-TIME ALL SALARIES		ADJUNCT ALL SALARIES	
		Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)	Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)	Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)	Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)	Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)	Semi-Mo Payroll (24 Deductions)	Bi-Wkly Payroll (26 Deductions)
Blue PPO	Individual	$48.35	$44.63	$78.12	$72.11	$94.35	$87.09	$110.27	$101.78	$141.31	$130.44	$204.51	$188.77
(those who live outside Rochester area)	2 Person	$113.58	$104.84	$166.37	$153.57	$192.09	$177.31	$158.33	$146.15	$308.39	$284.66	$450.40	$415.75
	Family	$175.35	$161.86	$251.32	$231.99	$283.96	$262.11	$229.95	$212.26	$402.60	$371.63	$553.88	$511.27
	One-Parent Fam	$123.11	$113.64	$173.26	$159.93	$197.60	$182.40	$162.96	$150.42	$320.71	$296.04	$468.15	$432.13

* Salary as of 1/1/22 or hire date, if later

9-Month Deductions

Medical Plan	Level of Coverage	Per Pay Period Employee Contribution				
		FULL-TIME SALARY LEVEL 1* Salary < $46,000	FULL-TIME SALARY LEVEL 2* Salary = $46,000-97,999	FULL-TIME SALARY LEVEL 3* Salary = $98,000-145,999	FULL-TIME SALARY LEVEL 4* Salary => $146,000	PART-TIME ALL SALARIES
		Nonexempt (26 Deductions)	Nonexempt (26 Deductions)	Nonexempt (26 Deductions)	Nonexempt (26 Deductions)	Nonexempt (26 Deductions)
Blue PPO	Individual	$61.07	$98.67	$119.17	$139.28	$178.50
(those who live outside Rochester area)	2 Person	$143.47	$210.15	$242.64	$278.85	$389.54
	Family	$221.49	$317.46	$358.68	$404.96	$508.55
	One-Parent Fam	$155.50	$218.85	$249.60	$286.99	$405.10

* Salary as of 1/1/2022 or hire date, if later