

ROCHESTER INSTITUTE OF TECHNOLOGY

Medical Care and Prescription Drug Plan

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RIT reserves the right to modify or terminate all or any portion of the employee benefits package at any time with or without notice. Such changes automatically will apply to you and your employment relationship with RIT. Participation in these plans is provided to eligible employees and does not constitute a guarantee of employment, and requires continued employment and eligibility.

Introduction

By providing protection against unexpected and catastrophic medical care expenses, your RIT Medical Care and Prescription Drug Plan (“the Plan”) is one of your most important and valuable benefit programs.

This summary is for regular faculty, regular staff, adjunct faculty, and adjunct staff, as well as pre-Medicare retirees, pre-Medicare LTD recipients, pre-Medicare spouses/domestic partners and eligible children, and pre-Medicare survivors

There is a separate summary for student employees who are eligible for coverage under the Affordable Care Act (“ACA”), also called Health Care Reform. The ACA has requirements for large employers such as RIT to offer medical coverage to employees who are “full-time,” as defined by the law; the ACA definition is different than RIT’s. Anyone who qualifies for coverage under the ACA is automatically sent the separate Summary Plan Description (SPD) *Medical and Prescription Drug Coverage for the ACA Group*.

This summary addresses important topics such as eligibility, changing your election, and what happens when your coverage ends. These general Plan provisions apply to all of non-ACA medical plans. This document, together with the annual *Medical Benefits Comparison Book* (found on the HR website at www.rit.edu/benefits), constitute the RIT Medical Care and Prescription Drug Plan’s summary plan description as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Important Note About Passwords

Password security is critical due to the confidential, private, and financial data that is available online. The employee/participant/covered family member is responsible for maintaining security of their passwords and adhering to RIT information security policies and standards.

General Information

Who is Covered and When

Regular full-time and part-time employees scheduled to work nine or more months are eligible to participate in the plan 12 months per year; regular full-time and part-time employees scheduled to work less than nine months are eligible to participate in the plan when working. Adjunct employees are eligible to participate in semesters in which they work. If you elect coverage, it can begin on the first day of the month on or after your date of employment. You need to enroll, however, and authorize the payroll deductions to pay your share of the cost before coverage can begin. However, if your contribution is too high to be deducted from your pay, we will set you up for billing by our outside billing administrator and you will pay with after-tax dollars. You must enroll within 31 days from your date of hire; otherwise, you cannot enroll until the fall open enrollment, effective January 1 of the following year. If you are not at work on the day coverage is supposed to start, coverage will become effective on the day you return to active employment.

You also may obtain coverage for your spouse or domestic partner and/or eligible children by enrolling in two person or family coverage and authorizing payroll deductions to pay your share of the cost. You may not cover your spouse/domestic partner as a dependent if your spouse is enrolled for coverage as an employee. No child can be covered as both an employee and a dependent.

Please refer to the [separate summary](#) on providing benefits for your domestic partner.

The eligibility rules for children are as follows:

- The child of the employee or the employee's spouse who is under age 26.
- The child of the employee's domestic partner who is under age 26 (*NOTE: if the child is not claimed as a dependent on the employee's federal income tax return, this benefit will be taxable*).
- The foster child (under age 18) of the employee, defined as an individual who is placed with the employee by an authorized placement agency or by judgment decree, or other court order.
- Any other child who is under age 26, and
 - for whom the employee is the legal guardian or custodian, and
 - who resides in the employee's home, and
 - who is claimed as a tax dependent on the employee's federal income tax return.

Coverage for your family members usually begins when your coverage begins. However, if your spouse/partner or a child is confined in an institution or at home for medical reasons when coverage is supposed to begin, coverage will become effective on the first day the person is no longer confined.

A spouse who is divorced from you is not eligible for coverage under the Plan (except under the provisions of COBRA, as described later in this summary), even if a court orders you to provide health care coverage for your former spouse. If you have an eligible dependent who is also an RIT employee, he or she may be covered either as an employee or as a dependent, but not both.

Also eligible for coverage under this Plan are those in the following categories who meet the requirements described later in this summary:

- Pre-Medicare retirees and pre-Medicare spouse/partner/children
- Pre-Medicare LTD recipients and pre-Medicare spouse/partner/children
- Pre-Medicare surviving spouse/partner/children.

Proof of Eligibility for Family Members

RIT has a family member verification (FMV) process to ensure that only those people who are eligible for benefits are covered and that the proper tax status is applied. It is important that RIT and employees are spending money as intended and that required taxes are paid.

The process is a simple one; copies of the eligibility verification documents only need to be provided ***once*** for an individual regardless of future benefit plan enrollments (e.g., if you cover your spouse only under dental and later add your spouse to your medical coverage, you will not need to provide another copy of the verification document).

Generally, the approved documents are a marriage certificate for a spouse and a birth certificate for a child, and an affidavit for your eligible domestic partner; refer to the benefits page of the HR website for more details on accepted documents. Copies of verification documents should be provided as follows:

New hires: a new employee must provide the eligibility verification documents before family members can be added to the various benefits coverage.

Mid-Year Changes: generally, the employee must provide the eligibility verification documents before family members can be added to the various benefits coverage. In the case where the document is not available (e.g., birth certificate for a new baby), the family member will be added to the coverage but the employee must

provide the required proof within 30 days; otherwise, coverage will be cancelled for the family member.

Open Enrollment Changes: the employee must provide eligibility verification documents by the end of the open enrollment period for any family members added to the coverage. If the documentation is not provided, the open enrollment change will not be processed and the family member will not be added to the coverage effective January 1.

Providing Social Security Numbers for Family Members

The Affordable Care Act (ACA) requires an employer who offers employee medical coverage to submit detailed reporting regarding **all** the people covered by the medical plan. One of the required items that RIT must report to the government is the name and Social Security Number (SSN) of each covered family member of an employee.

Therefore, RIT collects the SSN for each covered family member on the enrollment/change form. Please be assured that this information will be safeguarded with the same level of security protection we provide for all employee confidential data.

You Need to Enroll

Plan coverage is not automatic for a new employee; you need to complete an enrollment form for coverage to take effect. On the form you indicate your choice of medical plans and whether you want individual, two person, family coverage, or one-parent family (i.e., employee and two or more children) coverage.

It's important for you to return the completed enrollment form within 31 days after you first become eligible for coverage. If you wait beyond 31 days to enroll, you will not have another opportunity to enroll until the Plan's next open enrollment. If you have initially enrolled in one of the medical plans and wish to change to another plan, you may do so only at open enrollment.

Open Enrollment

Because medical coverage needs change from time to time, you have the opportunity once each year – effective as of January 1 - to make changes in your election. You can enroll in or cancel coverage, change plans, or change your coverage level (e.g., change from individual to two person). If you do *not* make a change during this open enrollment period, you will have to wait until the next open enrollment period to make a change unless you experience a qualified change in status, described in the next section.

Election Changes During the Plan Year

In general, once you have enrolled in the Plan, you cannot change plans, change your coverage level or cancel coverage until the beginning of the next plan year. However, pursuant to federal regulations, you may be able to make mid-year election changes if you meet certain criteria, as explained in items one through six, below. Your requested election change must be consistent with the reason for the change, as defined by the Internal Revenue Service. For example, it would be consistent for an employee with two-person coverage that adopts a child during the year to change his or her election to family coverage. It would not be consistent to move from family coverage to individual coverage. Changes must be made within 31 days of the event that gives you the right to make a new election. The Plan Administrator may require you to submit certain documentation related to your reason for making a mid-year election change. New elections will become effective on the qualifying event date.

Your benefit elections may be changed within 31 days – consistent with the event - to reflect the following events:

1. Qualified Change in Status

The following events constitute a qualified change in status:

- a change in legal marital status: for example, a marriage or divorce
- a change in the number of dependents: for example, the birth of a child, an adoption, a death, and so on
- a change in a dependent's eligibility: for example, a child reaches the maximum age under a medical plan
- a change in your residence or that of your spouse or child: for example, a move out of a geographic area covered by a medical plan
- you, your spouse or your child become eligible for continued health coverage under federal law (COBRA) or similar state law
- you, your spouse or your child become entitled to or lose Medicare or Medicaid coverage

2. Change in Employment Status

The following events constitute a change in employment status where they affect you or your spouse or child:

- termination of employment
- commencement of employment
- commencement or return from an unpaid leave of absence
- change in employment classification that makes the person either eligible or ineligible to participate in a plan (for example, a change from full-time to part-time status, or the reverse, if such a change affects one's eligibility to participate in a plan).

3. Changes in Employee's Cost of Coverage

With respect to your pre-tax premium contributions, you are permitted to make a mid-year election change if there is a significant increase in the cost of an underlying health care plan. If there is an ordinary increase or decrease in premiums, your payroll deductions will be automatically adjusted to reflect this change. Any determination of what constitutes a "significant increase" will be made by RIT.

4. Changes in Coverage

You may make a change in your election regarding your pre-tax premium contributions consistent with the following changes in coverage in an underlying health care plan:

- If the coverage provided by an underlying plan is significantly curtailed, you may revoke your prior election with regard to that plan
- If a new health care option is added or an option you have selected is eliminated, you may make a new election.

5. Qualified Medical Child Support Orders (QMCSO)

If a court ordered judgment requires you to provide health care coverage for a child or foster child, or if the order requires someone else to provide coverage, which you were previously providing, you may make mid-year election changes consistent with the QMCSO.

6. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Losing eligibility for coverage under a non-RIT plan may allow you to exercise special enrollment rights provided by HIPAA and make a mid-year election change.

Who Pays For This Protection

You and RIT share the cost of your medical plan, with the employee contribution being deducted from your paycheck, usually on a pre-tax basis. However, if your contribution is too high to be deducted from your pay, we will set you up for billing by our outside billing administrator and you will pay with after-tax dollars. Your share of the cost will be based on the plan you select and whether you choose individual, two person, one parent family or family coverage.

Contribution rates for medical coverage are provided annually by the Human Resources Department; the published rates include both the medical and prescription drug costs, if applicable, on a combined basis. These rates are subject to change. You will be notified in the event of any change in rates.

There are four cost sharing levels for full-time employees, based on the employee's annual base pay; part-time employees and adjunct employees each have their own cost sharing schedule.

Effective January 1, 2024, regular full-time employees will pay for coverage based on their annual base pay as follows; these salary levels are generally adjusted on an annual basis, effective each January 1.

- Level 1: less than \$48,000
- Level 2: \$48,000-\$103,999
- Level 3: \$104,000-\$153,999
- Level 4: \$154,000 or more

Pre-Medicare retirees and pre-Medicare LTD recipients as of January 1, 2006 are in cost sharing Level 2. Employees who retire after January 1, 2006 or those who are approved for LTD after January 1, 2006 remain in the cost sharing level they were in prior to retirement or the LTD effective date.

Pre-Medicare retirees and surviving family members covered by the Plan are billed monthly by our outside billing administrator. LTD recipients will have their contribution amount deducted from the insurance company's LTD benefit payment unless the deduction is higher than the payment; if that occurs, LTD recipients will be billed monthly by our outside billing administrator. All payments are made on an after-tax basis.

Refer to the separate contribution summaries for the employee contribution amounts and retiree/LTD/survivor contribution amounts. These rates are subject to change.

Recovery of Overpayments

If any benefit is paid in error to you or a provider (e.g., hospital, physician, pharmacy), the Plan has the right to recover the amount overpaid. You, your dependent or legal representative shall, on request, provide the Plan with information, sign any documents, make repayment, and do whatever else the Plan says is necessary to recover an overpayment. Any failure to cooperate may result in the Plan's seeking reimbursement directly from you, your dependent or your estate, through legal action.

Coordination of Benefits

If you have medical coverage under another group plan in addition to this one - through that of a spouse/partner, for example - the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate this duplicate spending, our Plan's coverage is coordinated with other group plans with which you have coverage. This means that when the RIT Plan pays second, benefits will be adjusted so that the total payments from both plans won't be more than 100% of total covered charges.

For your own claims and those of your spouse/partner, the plan that pays first is the one that covers you, your spouse or partner as an employee. If your children are covered by more than one plan, the plan of the parent

whose birthday occurs earlier in the year will pay benefits first. However, if you are separated or divorced, the plan of the parent who has financial responsibility for the child's medical care expenses will pay first. If there is no court decree for medical care coverage, then the plan of the parent who has custody of the child will pay first. Where none of these situations apply, the plan that you're covered under the longest will pay first.

Other plans include any medical coverage available through:

- Any group or blanket insurance contract, plan or policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
- Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization, or employee benefit organization;
- Any BlueCross BlueShield, or other service type group plan;
- Any coverage under governmental programs, or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and
- Medical benefits coverage in group and individual mandatory automobile "no fault" and traditional "fault" type contracts.

When You (or Your Spouse) Become Eligible For Medicare and You are Still Working

Medicare, which is a federally sponsored medical insurance plan, becomes available at the beginning of the month in which you (or your spouse) turn age 65 (if the birth date is the first of the month, Medicare becomes effective the first of the prior month). There are special rules for people age 65 or over who are actively working, or who are being covered by a spouse, if the spouse is actively working. An employer must offer the same medical plans to an active employee (or spouse of an active employee) who is age 65 and over as they do to active employees who are under age 65.

Therefore, you (or your spouse) can continue to be covered under the same RIT medical plan with the same level of benefits when you turn age 65. All references below to "you" also apply to your spouse.

Under Federal law, this special rule does not apply to a domestic partner. While the domestic partner can continue to be covered under the RIT coverage, Medicare will be the primary coverage and the RIT coverage will be secondary. Refer to the additional information below.

Medicare Part A-Hospital Insurance

The Social Security Administration (SSA) recommends that you enroll in Medicare Part A beginning the first of the month in which you turn age 65. Medicare Part A is the hospital insurance and pays some of the cost of hospitalization, inpatient hospital care, and home health services. There is no premium during retirement for Medicare Part A benefits (these are funded through payroll taxes while you are working) and it will be secondary to your RIT employee coverage. Part A is not set up automatically; you will need to contact the Social Security Administration at 800-772-1213 or enroll online at <https://www.ssa.gov/benefits/medicare/> to ensure that you are enrolled in Medicare Part A. If you do not enroll in Medicare Part A at age 65, Medicare provides a special enrollment period when you leave or retire from RIT.

For domestic partners, Medicare Part A will be the primary coverage; the RIT coverage will be secondary.

Medicare Part B-Medical Insurance

If you continue to work as a regular employee at RIT and have RIT medical coverage, it is not necessary for you to enroll in Medicare Part B and pay the required Part B premium; Part B covers medical care (doctor's fees, etc.). When contacting the SSA you should let them know you do not need Part B coverage since you are still working and have RIT coverage. When you leave or retire from RIT, Medicare provides a special enrollment period to enroll in Medicare Part B benefits, with no penalty. You should begin this special enrollment process at least three months prior to your retirement/termination date.

A domestic partner needs to enroll in Medicare Part B; there will be a premium for the Part B coverage that is payable to the Social Security Administration. Medicare Part B will be the primary coverage; the RIT coverage will be secondary. Please note that the Plan is administered as if the domestic partner has Medicare Part B, so it is critical to enroll to avoid gaps in coverage.

Medicare Part D-Prescription Drug Insurance

You do not need to enroll in any Part D prescription plan when you turn 65 as long as you are enrolled in creditable coverage from RIT. Creditable coverage is defined as coverage that is at least as good as standard Medicare prescription drug coverage. If you do not have creditable coverage, you will have a Part D late enrollment penalty from Medicare when you ultimately retire.

Creditable Coverage (RIT Rx Plan 1)

- Blue Point2 POS A
- Blue Point2 POS B
- Blue PPO

NOT Creditable Coverage

- Blue Point2 POS B No Drug (there is no prescription drug coverage)
- Blue Point2 POS D (RIT Rx Plan 2)

If you are enrolled in an RIT plan that does not have creditable coverage and you are not covered by other creditable coverage (e.g., spouse's plan, Veteran's coverage), you should consider enrolling in a Medicare Part D prescription drug plan.

There are no special rules for a domestic partner for prescription drug coverage; the rule is the same as explained above for employees.

Medical and Prescription Drug Options

- Point of Service (POS)
 - Blue Point2 POS A
 - Blue Point2 POS B
 - Blue Point2 POS B No Drug (enrollment frozen as of 1/1/2025)
 - Blue Point2 POS D
- Preferred Provider Organization (PPO)
 - Blue PPO (*available only to employees/LTD recipients/retirees residing outside the POS service area*)

Prescription drug coverage is separate from the medical plan and is administered on RIT's behalf by a Pharmacy Benefit Manager (PBM). OptumRx is the currently designated PBM for RIT's prescription drug coverage. You will be automatically enrolled in a prescription drug plan based on the medical plan you elect as follows:

POS A, B, Blue PPO	Rx Plan 1
POS D	Rx Plan 2
POS B No Drug	No Rx Coverage (except limited coverage as described in the annual <i>Medical Benefits Comparison Book</i> under the category "Prescription Drug Coverage under Medical Plan.")

The Plan is self-funded – that is, all benefits provided under the Plan are paid for by RIT from its general assets. RIT does not process the claims for Plan benefits.

- RIT has entered into a contract with Excellus BlueCross BlueShield ("Excellus") to process medical claims and to provide certain other services under the Plan. This contractual arrangement does not insure Plan benefits through Excellus.
- RIT has entered into a contract with OptumRx to process prescription drug claims and to provide certain other services under the Plan. This contractual arrangement does not insure Plan benefits through OptumRx.

As a result, persons covered by the Plan do not have any insured or other contractual relationship with Excellus or OptumRx for benefit payments under the Plan.

Coverage Information-Medical Benefits

You will find details about covered services for POS A, POS B, POS B No Drug and POS D in the *Medical Benefits Comparison Book*. There is a separate summary for the Blue PPO. Excellus BlueCross BlueShield administers medical claims under this Plan.

Medical ID Cards

When you first enroll in the RIT coverage, you will receive two identification cards from Excellus, both of which will have the employee's name on them. If you need additional cards (for instance, if your child is attending college out of town), you can request them by contacting Excellus Customer Service. In an emergency, you are able to print a temporary identification card from the Excellus website. Your ID card is also available to be viewed on the Excellus app for your mobile device.

Annual Out-of-Pocket Maximums

An out-of-pocket maximum provides protection for plan participants who have high medical and/or Rx expenses since it limits the total amount you will have to pay during the plan year. The medical benefit and the prescription drug benefit each have a separate out-of-pocket maximum. This means that medical expenses count only toward the medical plan out-of-pocket maximum, while prescription drug expenses count only toward the prescription drug out-of-pocket maximum. And in both cases, only covered plan expenses count toward the out-of-pocket maximums; non-covered expenses do not count. You will find the amounts listed in the *Medical Benefits Comparison Book*. Once you reach your medical out-of-pocket maximum, the medical plan will cover you in full at 100% for your eligible plan expenses for the remainder of the plan year.

Rochester Regional Health and RIT Alliance and How RIT Employees Can Benefit

As an RIT employee, you can benefit from RIT's strategic alliance with Rochester Regional Health in several ways. You will find information below about how to take advantage of the resources provided by RIT's official affiliated clinical partner.

Rochester Regional Health (RRH) Copay Option

Under the "RRH Copay Option" within our point of service (POS) medical plans, there are lower copays when you obtain the following medical services from RRH providers:

- office visit to primary care physician (PCP)
- office visit to specialists
- emergency room visits

For POS A only, the RRH Copay Option also applies to Inpatient Hospitalization and Outpatient Services.

Please note that the lower copays do not apply to tests, treatments or any other services not listed above (e.g., allergy shots, chiropractic services, physical therapy, x-rays, etc.). These lower copays are outlined in each applicable section of the *Medical Benefits Comparison Book*.

If you use an RRH provider and believe you are not being charged the proper copay, you can request that they verify the copay with Excellus.

Finding an RRH Provider for RIT Employees and Pre-Medicare Retirees

It can be challenging to find a primary care physician in the area who is accepting new patients, and this is equally true for some specialties. To help employees and pre-Medicare retirees locate a physician within the RRH network, use the [Find a Doctor](http://www.rochesterregional.org/physician-directory) search tool (www.rochesterregional.org/physician-directory).

In addition, we post an [updated list of participating providers](#) on the HR website (Health Care section) that RRH provides to RIT. You can use this list to help you find RRH participating physicians and/or identify whether your provider is affiliated with the RRH network. The list includes the provider's name, address, phone number and specialty. Since the list is quite lengthy, we recommend that you search for any of the fields (name, specialty, etc.) instead of printing the entire list. To search, simply hold down the CTRL key (the ⌘ Command key for Macs) and press the F key, then enter the text you are searching for and click Next.

Important Note: *Since participating physicians can change from time to time, before scheduling an appointment with a provider from this list, you should verify that they still participate in the RRH network.*

If you have any questions about searching for a provider, you can call the RRH referral help line at (585) 922-7480/V.

Rochester Regional Health Family Medicine at RIT

The [Rochester Regional Health Family Medicine](#) practice opened on the RIT campus in fall 2015. The convenient practice offers a wide range of primary care services and you can designate the practice physician, Dr. Eric Wilcox, as your primary care physician if you choose. Participants in RIT's pre-Medicare point of service plans (POS) medical plans pay a lower copay for an office visit at the practice than at other participating providers.

Exclusions Under the Medical Coverage

The plan does not provide coverage for the following:

- Any service or supply that is not specifically included as a covered service in the plan, even if it is prescribed, provided, recommended, approved or referred by a health care provider, except as deemed medically appropriate by Excellus BlueCross BlueShield.
- Any service or supply that is in excess of a limit specified in the plan.
- Any service or supply that is incurred prior to the covered person's coverage under the plan, or after the covered person's plan coverage terminates.
- Any claim submitted past the claim-filing deadline, generally within 12 months following the date the service was rendered.
- Any service or supply that is not prescribed, recommended and approved by a health care provider.
- Treatment that is not medically necessary, as determined by Excellus BlueCross BlueShield.
- Services or supplies that are experimental or investigational, as determined by Excellus BlueCross BlueShield.
- Any portion of a charge for a service or supply that exceeds the allowable expense for such service or supply.
- Any service or supply that is normally provided without charge, or for which a charge is made solely because the plan would cover such service or supply, or which the patient is not legally obligated to pay.
- Any service or supply available under any government program unless required by state or federal law. When a covered person is eligible for Medicare, benefits under the plan will be reduced by the amount Medicare would have paid for the services; except as required by law, this reduction is made even if the covered person fails to enroll in Medicare, does not pay the charges for Medicare or receives services at a facility that cannot bill Medicare. This exclusion does not apply if the covered person is entitled to Medicare benefits by reason of age, disability or end-stage renal disease, is in current employment status and the plan is required by law to pay its benefit before Medicare.
- Any service or supply provided by a hospital or other institution which is owned, operated or maintained by the U.S. Veteran's Administration, federal, state or local government, unless the hospital or institution is a participating provider or the care consisted of emergency care covered under the plan.
- Any service or supply provided by a person or entity acting outside the scope of his, her or its license, or by an unlicensed provider.
- Services or supplies that a covered person's employer is required to provide by federal state or local law, including services or supplies for which coverage is available under a Workers Compensation arrangement.
- Any expense for conditions or services that are reimbursed by a third party, including no-fault automobile insurance.
- Any expense for services or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
- Any service or care to the extent covered under any other health benefits contract, program or plan.
- Certification examinations, including but not limited to those required for school, employment, insurance, marriage, licensing, travel, camp, sport or adoption.
- Cosmetic services that are primarily intended to improve appearance and not medically necessary, as determined by Excellus BlueCross BlueShield.
- Court-ordered services, including evaluation, testing and/or treatment, medical reports not related to treatment or prepared in connection with litigation, or that is required by a court as a condition of parole or probation.
- Custodial care primarily for the purpose of meeting personal needs, including activities of daily living such as help in transferring, bathing, dressing, eating, toileting and such other related activities; or therapy that is not expected to improve the covered person's condition, as determined by Excellus BlueCross BlueShield.

- Dental care, except for: medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, as approved by Excellus BlueCross BlueShield's medical director; treatment of a congenital anomaly or disease that was evident at birth and caused by a medical condition that was present at birth; services determined as medically necessary by Excellus BlueCross BlueShield for treatment of cleft palate and ectodermal dysplasia; and in rare situations when more complex anesthesia than can be delivered in a dental office setting is determined to be medically appropriate under Excellus' medical policy, coverage for ambulatory surgery unit and anesthesia.
- Any service or care related to medical supplies (such as bandages, surgical gloves and compression stockings); disposable supplies (such as diapers, sponges, syringes, incontinence pads); wigs, hair prosthetics or hair implants; and the purchase or rental of household fixtures.
- Reversal of elective sterilization.
- Hypnosis/biofeedback.
- Nutritional therapy, unless ACA and/or Federal Mental Health Parity guidelines are met.
- Personal comfort services such as radio, telephone, television, or beauty/barber services.
- Prescription drugs, over-the-counter (nonprescription) drugs, or injections, except for prescription drugs and/or injections administered in the course of a covered outpatient or inpatient treatment in a facility or health care provider's office, or through home health care benefits, or as required to be covered by medical plans under Federal law.
- Private duty nursing services, even if ordered by a health care provider.
- Prohibited referral, including coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.
- Reproductive procedures in connection with in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and donor fees associated with artificial insemination or other procedures, or other procedures excluded by law.
- Routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails or symptomatic complaints of the feet.
- Self-help diagnosis, training and treatment for recreational, educational vocational or employment purposes.
- Services that should have been covered under a hospice care program related to terminal illness.
- Miscellaneous charges for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, completion of claim forms, late charges or extra day charges incurred upon discharge from a facility because the covered person did not leave the facility before the facility's discharge time.
- Smoking cessation programs, except for the *Quit for Life* program offered through Excellus BlueCross BlueShield.
- Social counseling and family, marital, religious, sex or other therapy, except as otherwise specified as covered under the plan.
- Transsexual surgery and related services designated to alter the physical characteristics of biologically determined gender to those of another gender, unless determined as medically necessary by Excellus BlueCross BlueShield.
- Vision therapy, vision training and orthoptics.
- Weight loss programs, or services in connection with weight reduction or dietary control, including but not limited to laboratory services, gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless determined to be medically necessary by Excellus BlueCross BlueShield.

Coverage Information-Prescription Drug Benefits

OptumRx is the pharmacy benefit manager (PBM) which administers RIT's prescription drug coverage. Under the plan, covered medications can be purchased from a participating retail pharmacy or from OptumRx's mail pharmacy. You will find the current copay information in the annual *Medical Benefits Comparison* book as well as in the Plan Design section of this summary.

Please note this section does not apply to those Medicare-eligible individuals covered under the BlueCross BlueShield Comprehensive Plan in 2019. Refer to the prescription drug information in the separate benefits summary for that plan.

There are two prescription drug plans, depending on which medical plan you elect. You will be automatically enrolled in a prescription drug plan based on the medical plan you elect as follows:

POS A, B, Blue PPO	Rx Plan 1
POS D	Rx Plan 2
POS B No Drug	No Rx Coverage (except limited coverage as described in the annual <i>Medical Benefits Comparison Book</i> under the category "Prescription Drug Coverage under Medical Plan.")

All plan details described in this section apply to both Rx Plan 1 and Rx Plan 2.

Annual Out-of-Pocket Maximums

An out-of-pocket maximum provides good protection for plan participants who have high medical and/or Rx expenses since it limits the total amount you will have to pay during the plan year. The medical benefit and the prescription drug benefit each have a separate out-of-pocket maximum. This means that medical expenses count only toward the medical plan out-of-pocket maximum, while prescription drug expenses count only toward the prescription drug out-of-pocket maximum. And in both cases, only covered plan expenses count toward the out-of-pocket maximums; non-covered expenses do not count. You will find the amounts listed in the *Medical Benefits Comparison Book*. Once you reach your Rx out-of-pocket maximum, the Rx plan will cover you in full at 100% for your eligible plan expenses for the remainder of the plan year.

Prescription ID Cards

When you first enroll in the RIT coverage, you will receive two prescription drug identification cards from OptumRx, both of which will have the employee's name on them. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling OptumRx Member Services. In an emergency, you are able to print a temporary identification card from the OptumRx website. Your ID card is also available to be viewed on the OptumRx app for your mobile device. It is important to remember to *use your prescription drug ID card at the pharmacy*, rather than your medical ID card. Your ID card is also available to be viewed on the OptumRx app for your mobile device.

Retail Pharmacies

OptumRx has contracted with a broad national network of retail pharmacies. This network includes thousands of pharmacies throughout the United States, including nearly all major retail pharmacy chains, such as CVS and Rite Aid, certain stores containing pharmacies such as Wegmans, Target, Tops, and Wal-Mart, and most smaller, independent pharmacies, including nearly all in the Rochester area. Retail pharmacies in the OptumRx network are referred to as "participating pharmacies." To locate a participating pharmacy close to your home or other location, you can call OptumRx Member Services or check OptumRx website at www.optumrx.com.

Preferred Pharmacy

Wegmans Pharmacies are designated as the “preferred pharmacy” under the plan. Wegmans offers the convenience of a local pharmacy paired with the preferred pricing typically available only at a mail pharmacy. Wegmans also has a free home shipping option available.

Because of this special designation, your copay is lower when you purchase your medications at Wegmans than at other retail pharmacies. You are also able to purchase up to a 90-day supply of your medications at Wegmans, but only up to a 30-day supply at other retail pharmacies. Your copay for a 90-day supply at Wegmans is equal to your copay at the mail pharmacy, and lower than the total of three 30-day copays that you would pay at another participating retail pharmacy. You may choose to purchase 30-day supplies at Wegmans and your copay will not increase after 3 fills; at other retail pharmacies, your copay for a maintenance medication (those drugs you take for an ongoing medical condition) will increase significantly after 3 fills. And RIT’s plan cost will be equivalent overall when you purchase your medications at Wegmans compared with the mail pharmacy and significantly lower than at other retail pharmacies, which will help keep the plan affordable in the future. Refer to the Plan Design section for details.

Please note if you are in Rx Plan 2 and have not yet met your annual deductible, you will pay RIT’s applicable contracted price at a retail pharmacy, including Wegmans. In this situation, you may want to compare the pricing since the OptumRx contracting varies among retail pharmacies.

Nonparticipating Retail Pharmacy

When your prescription is filled at a nonparticipating retail pharmacy, your copays are as indicated in the copay charts, *plus* you will pay any cost difference between the nonparticipating pharmacy’s prescription price and OptumRx’s discounted network prescription price. You will be required to pay the full cost of the prescription at the time you make your purchase; you must then submit a paper claim to OptumRx to receive reimbursement from the plan. The reimbursement process is described in the section “Using a Reimbursement Form.”

Mail Pharmacy

For maintenance medications (those prescriptions you take on an ongoing basis), OptumRx’s mail pharmacy offers the convenience of home delivery. Your initial prescription will be delivered within 10 to 14 days of receipt. Refills can be ordered online at www.optumRx.com and are typically delivered within seven to 10 days. The mail pharmacy has registered pharmacists available to answer questions about your medication or reactions 24 hours a day, seven days a week.

See the section “Prescription Drug Claims and Payment of Benefits” for detailed instructions on using OptumRx’s mail pharmacy. On rare occasions, a particular drug will not be available through the mail pharmacy. In this situation, you will need to fill your prescription at a participating retail pharmacy and pay the applicable retail pharmacy copay.

Please be sure that your physician provides a prescription for a 90-day supply when you are ordering from the mail pharmacy. The mail copay is based upon a 90-day supply, but if your prescription is written for a lesser supply, the same mail copay will apply.

Covered Medications

Except as specified in the section “Exclusions and Benefit Limitations,” the prescription drug plan provides coverage for Federal legend drugs, which are drug products bearing the legend “Caution: Federal law prohibits dispensing without a prescription.” The prescription drug plan also covers certain prescription supplies and some compound medications which contain at least one Federal legend drug in a therapeutic amount.

Contraceptives are covered as required by Federal law, and coverage details can be found in the *Medical Benefits Comparison Book*.

In order for a prescription to be covered by the plan, the prescribed item must meet the following requirements:

- It must be prescribed by a licensed physician.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a pharmacy.
- It must meet the plan's special requirements for certain drugs, and
- It must not be listed under "Exclusions and Benefit Limitations" in this summary.

Prescription drugs covered by the plan are classified as either generic or brand name drugs. Generic drugs are sometimes referred to as Tier 1 drugs. Brand name drugs are also considered either preferred or non-preferred. You may sometimes see preferred brand name drugs referred to as formulary or Tier 2 drugs. Non-preferred brand name drugs may be referred to as non-formulary or Tier 3 drugs. In summary, here are the tiers and which type of drugs fall into each category:

The Various Tiers are	Also Called	Also Called
Tier 1	Generic	N/A
Tier 2	Preferred	Formulary
Tier 3	Non-preferred	Non-Formulary

Generic Drugs

New drugs, like many other new products, are developed under patent protection. The patent protects the investment in the drug's development by giving the manufacturer the exclusive right to sell the brand name drug while the patent is in effect. When patents or other periods of exclusivity on brand name drugs expire, pharmaceutical manufacturers can apply to the FDA to sell generic versions.

Generic drugs must meet strict FDA requirements for safety and effectiveness. The proposed generic equivalent must have an FDA-approved brand name drug that is the "same" in terms of:

- Active ingredient(s)
- Labeled strength, and labeling information
- Dosage form, such as tablets, patches and liquids
- Administration – for example, swallowed as a pill or given as an injection
- Bioequivalence – performs in the same manner as the brand name drug
- Quality, purity and stability under extremes of heat and humidity

Generic drugs generally cost less than brand name drugs. They often have a different appearance (e.g. color, shape) and different inactive ingredients from their brand name counterparts for ease in identification, but this does not impact their therapeutic performance.

Brand Name Drugs

Brand name drugs are medications and supplies requiring a prescription which are distributed under a trademarked name by the pharmaceutical manufacturer whose new drug application was approved by the FDA.

Preferred and Non-Preferred Brand Name Drugs

For the treatment of many conditions, there are several drugs available, both brand name and generic. OptumRx has a list of preferred drugs, called a "formulary." Medications on the formulary are evaluated for safety and effectiveness by an independent Pharmacy and Therapeutics Committee consisting of practicing

physicians and clinical pharmacists who are not employed by OptumRx. Formulary medications are selected based on their safety and effectiveness, along with the opportunity for cost savings.

The formulary is updated quarterly. New drugs are added, and sometimes a drug can change categories, for example, from preferred to non-preferred. A current list of preferred drugs is available on OptumRx's website or by calling their Member Services telephone number.

Brand name drugs that are not on the formulary are considered non-preferred. Unless specifically excluded by the plan (see "Exclusions" section of this summary), these drugs are covered by the prescription drug plan, but you pay a higher copayment than for generic or preferred brand name drugs.

Specialty Medications

If you are prescribed a specialty medication, you generally must fill it with OptumRx Specialty Pharmacy in order to have coverage. There are a few limited situations in which an exception may be granted in advance by OptumRx and the medication may be purchased at a participating retail pharmacy. Please call OptumRx Customer Service at the dedicated Rochester Institute of Technology toll-free member phone number 1-855-209-1300 (TTY: 711) or visit www.optumrx.com for more information.

A specialty medication is an injectable, oral or inhaled medication, typically used to care for certain rare and complex conditions, which:

- May require ongoing clinical oversight and additional education for best management;
- Has unique storage or shipping requirements;
- May not be available at retail pharmacies.

Examples of conditions that may require specialty medications are multiple sclerosis, rheumatoid arthritis, cancer, transplants and hepatitis.

Specialty medications are typically high priced, costing more than \$1,000 for a 30-day supply. They are complex, meaning that the drug imitates compounds found in the body and is part of a specialty drug class. And they are high-touch because they have special shipping or handling requirements, such as refrigeration, and need a physician or pharmacist to measure how well it works for you.

OptumRx Specialty Pharmacy offers support to help you manage your condition. Take advantage of personalized patient support from knowledgeable pharmacists and nurses who specialize in your condition at no additional cost to you. In addition, you will receive:

- 24/7 access to pharmacists
- Support through clinical and adherence programs
- Any medication-related supplies at no additional cost
- Proactive refill reminders
- Timely delivery and shipping in confidential packaging
- Free video consultations with an OptumRx clinician
- Free videos designed to help provide patients with tips along the way in regard to select specialty conditions.

Plan Design

Your cost for a prescription will be based on a tiered copay structure, and will differ depending on:

- The drug's tier – generic, preferred (formulary), or non-preferred (non-formulary);
- Whether you choose (or your doctor prescribes) a brand name drug when a generic is available;
- Whether you purchase your drug at Wegmans Pharmacy (the plan's preferred pharmacy), a different participating retail pharmacy or through the PBM's mail pharmacy;

- Whether you purchase your drug from a participating or non-participating retail pharmacy; and
- Whether your prescription is subject to any special limitations or procedures.

Your copay will never exceed the full price of the medication.

Important Information About Copays for Maintenance Medications

If you take maintenance medications (those you take for an ongoing medical condition), there is a significant financial incentive to purchase them at Wegmans, our preferred retail pharmacy, or through OptumRx’s mail pharmacy.

On the 4th fill (original plus 3 refills) of a maintenance prescription filled at a retail pharmacy (other than Wegmans), your copay for a 30-day supply will be equal to the copay for a 90-day supply of the medication if you ordered it from OptumRx’s mail pharmacy or purchased it at Wegmans. This will result in greatly increased copays if you continue to fill your maintenance medications at a retail pharmacy other than Wegmans beyond the 3rd fill.

This higher copay does not apply to acute care drugs such as antibiotics – your copays for such medications purchased at a retail pharmacy will not change. Also, certain medications are not available from OptumRx’s mail pharmacy, such as certain controlled substances; the higher copay will also not apply in these situations. The rest of the cost of your drugs will be paid by the prescription drug plan, except as described below.

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 chooses the brand name drug, *regardless of the reason*, you will be required to pay the difference in cost between the brand-name drug and the generic, in addition to the applicable copay.

If you purchase your medication at a nonparticipating pharmacy, you will be required to pay the full cost at the pharmacy. You can then file a claim for reimbursement (described in the section “Claims and Payment of Benefits”) with OptumRx. Your cost will be the retail copay you would have paid at a participating pharmacy (other than Wegmans), plus any additional amount charged by the nonparticipating pharmacy above the amount the drug would have cost at a participating retail pharmacy.

Copay Information Rx Plan 1 (included with medical plans POS A, POS B, Blue PPO)

Under Rx Plan 1, you have “first dollar coverage,” meaning there is no annual deductible to meet before the plan begins to pay benefits.

CATEGORY	WEGMANS PHARMACY		OTHER RETAIL ⁽¹⁾		OPTUMRX MAIL
	30-day supply, no limit on fills	90-day supply	30-day supply, up to 3 fills	30-day supply 4th fill and after ⁽²⁾	90-day supply ⁽³⁾
Tier 1: Generic Drugs	\$15.00	\$37.50	\$17.00	\$37.50	\$37.50
Tier 2: Brand Name Formulary Drugs	\$35.00	\$87.50	\$40.00	\$87.50	\$87.50
Tier 3: Brand Name Non-Formulary Drugs	\$50.00	\$125.00	\$60.00	\$125.00	\$125.00

Copay Information Rx Plan 2 (included with medical plan POS D)

Under Rx Plan 2, there is a \$1,250 annual per person annual deductible. This means that, until you meet your deductible, you will pay the full cost of the medication; once you meet your deductible, you will pay copays for

your medications for the remainder of the plan year. You should show your card when you purchase prescriptions so you receive any negotiated discounts and so OptumRx can track the \$1,250 deductible.

CATEGORY	WEGMANS PHARMACY		OTHER RETAIL ⁽¹⁾		OPTUMRX MAIL
	30-day supply, no limit on fills	90-day supply	30-day supply, up to 3 fills	30-day supply 4th fill and after ⁽²⁾	90-day supply ⁽³⁾
Annual Deductible - each person must pay \$1,250 annual deductible before copay amounts are charged in a plan year					
Tier 1: Generic Drugs	\$25.00	\$62.50	\$30.00	\$62.50	\$62.50
Tier 2: Brand Name Formulary Drugs	\$70.00	\$175.00	\$80.00	\$175.00	\$175.00
Tier 3: Brand Name Non-Formulary Drugs	\$130.00	\$325.00	\$150.00	\$325.00	\$325.00

Important Notes for Rx Plan 1 and Rx Plan 2

- (1) 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 can submit a claim for reimbursement, but may be responsible for more than the copays listed above.
- (2) applies to maintenance medications only
- (3) the copays shown for OptumRx’s Mail pharmacy apply even if your prescription is written for less than a 90-day supply. To get the best advantage of this program, be sure your physician writes the prescription for a 90-day supply.

Exclusions and Benefit Limitations

The following are not covered by the prescription drug plan. Some of them may be covered by your medical plan.

- Medications and supplies which are specifically excluded from coverage by the plan’s Pharmacy Benefit Manager.
- Drugs subject to preferred drug step therapy where the requirements have not been satisfied.
- For drugs subject to quantity limits, any amount that exceeds the stated quantity limit.
- For any drug, a quantity in excess of a 90-day supply.
- A quantity greater than a 30-day supply when filled at a retail pharmacy other than Wegmans.
- Specialty medications which are not filled at the plan’s designated specialty pharmacy.
- Medications and supplies which are covered by your medical plan.
- Excess charges by a non-participating pharmacy beyond the allowed amount that would have been paid to a participating pharmacy.
- Medications ordered or purchased prior to the covered person’s coverage under the plan, or after the covered person’s coverage terminates.
- Non-Federal Legend and Over the Counter Medications (including drugs for which a prescription was formerly required, except if required to be covered under Federal law).
- Injectable drugs that are not self-administered.
- Biologicals (immunization agents and vaccines).
- Allergy serums.
- Blood or blood plasma products.
- Mifeprex.
- RU-486.
- Dental fluoride products.
- Ostomy supplies.
- Therapeutic devices or appliances.

- Drugs to promote or stimulate hair growth or for cosmetic purposes.
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Implantable time-released medications.
- Nutritional supplements, except for those included on OptumRx's list of approved nutritional products intended for treatment of specific metabolic conditions, and which are purchased through a pharmacy.
- Unit doses of medication.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Drugs requiring prior authorization for which a prior authorization was not obtained.
- Drugs which are new to market for which a coverage determination has not yet been made.
- Items not specifically described as covered by the Plan.
- Claims submitted past the 12-month claim filing deadline.

Prior Authorization

For certain medications, the prescription drug plan requires prior authorization by OptumRx before benefits will be paid. The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. In order to determine whether a specific medication has a prior authorization requirement, you can search by the name of the drug on OptumRx's website, www.optumRx.com, or call OptumRx Member Services. Prior authorizations are typically approved for a one-year period, unless otherwise noted.

To obtain a prior authorization, your physician must complete a OptumRx prior authorization form, which is available on OptumRx's website, www.optumRx.com or call OptumRx Member Services.

Preferred Drug Step Therapy

One of the features of the Plan is called "preferred drug step therapy (PDST)." The purpose of PDST is to ensure that a person has tried a particular preferred drug or drugs in a specific therapeutic category before the Plan will cover a more expensive drug in that category. It is often common for physicians to prescribe brand name drugs with which they are familiar, but that may not always be the most effective and cost effective choice of therapy. Only selected categories that have clinically accepted substitutes, determined by OptumRx clinicians, are part of the PDST program.

When your physician prescribes a brand name drug that is part of the PDST program, the Plan will only cover it if you have tried the clinically accepted alternative drug(s) and either:

- they have not worked for you, or
- there is a medical reason why you are unable to take the drug, such as an allergy to one of the ingredients.

If this information is in OptumRx's records, the brand name drug will be approved without any intervention needed by your physician. If this information is not in OptumRx's records (for instance, if you tried the other medication before you were covered by the Plan), the drug will not be covered without a coverage review and approval by OptumRx.

If your physician believes that you should use a medication that is not preferred, you or your physician can request a review for coverage. Your physician can call OptumRx toll-free at 800-626-0072, 8:00 a.m. to 10:00 p.m., Eastern Time.

If you obtain approval before filling your prescription, you will pay your applicable copay. If you obtain approval after filling your prescription, you will pay for the full cost of the medication at the pharmacy but will be able to be reimbursed for the covered cost of the medication minus the copay. In this case, you will need to file a manual claim in order to be reimbursed.

Please note that new categories may be added to the PDST program over time, and preferred drugs may change from time to time as new drugs become available, and as brand name drugs lose their patent protection and are available as generics.

Quantity Limits

For certain medications, there are limits on the quantity that will be covered. The list of medications that have quantity limits will change from time to time, and drugs that do not have quantity limits may require them in the future. In order to determine whether a specific medication has a quantity limit, you can search by the name of the drug on OptumRx's website, www.optumRx.com or call OptumRx Member Services.

Refill Limits

For refills from a retail pharmacy or specialty pharmacy 75% of the prior order of the medication must have been used before the prescription can be refilled; for the OptumRx mail pharmacy, 60% of the prior order of the medication must have been used before the prescription can be refilled. If you will be traveling and need to refill your prescription early, let the pharmacist know and request that he or she call OptumRx for a "vacation override."

Drug Utilization Review

Participating network pharmacies are given information by OptumRx that helps protect patients from interactions between current medications and a new drug being prescribed or other adverse reactions such as previously identified allergies. The pharmacist is alerted to a potential reaction at the time the new drug is entered into OptumRx's system at the point of purchase. The pharmacist can then discuss the situation with patient, and/or the patient's physician. This safety feature, which is also available to OptumRx mail pharmacy pharmacists, is especially important if more than one physician is prescribing medications for an individual, or if prescriptions are filled at different pharmacies.

Excluded Medications and Supplies

The Pharmacy Benefit Manager, OptumRx, has the authority to exclude specific medications and supplies from coverage. If an item is on this list of exclusions, the plan will not pay anything toward the cost, and you will be required to pay the full cost at the pharmacy. Any item on the excluded list has available substitutes which you can request your physician to prescribe. If your physician believes there is a medical necessity for you to continue with the medication that has become excluded from coverage, your physician should initiate a coverage review by contacting the coverage review team at OptumRx.

Prescription Drug Claims and Payment of Benefits

At a Participating Retail Pharmacy

Present your prescription drug (OptumRx) ID card when you purchase your medication at a retail pharmacy that is part of OptumRx's retail pharmacy network. You will be charged the applicable copay and any other applicable charges. The remainder of the cost will be paid to the retail pharmacy by the prescription drug plan. You do not need to file any claims. Remember you are limited to a 30-day supply **except** at a Wegmans Pharmacy, where you can fill up to a 90-day supply at one time.

Using the OptumRx Mail Pharmacy

Let your doctor know that you have a mail-order prescription drug benefit and that you would like to have the maximum supply of medication (usually 90 days) plus refills for up to one year. You may mail your prescription(s) in OptumRx mail pharmacy envelopes or ask your doctor to call 1-855-209-1300/V for instructions on how to fax the prescription. If your order is faxed, your doctor must have the member number from your OptumRx ID card.

When your doctor prescribes a new medication, it is recommended that you have your doctor write two prescriptions: one for a 30-day supply and one for a 90-day supply with refills. You should first fill the 30-day supply prescription at a retail pharmacy and try the new drug to ensure you will not experience any adverse reaction and that the drug will be effective for you. Once you determine that the new drug will work for you, you can fill the 90-day prescription through OptumRx mail pharmacy, if you choose, but you have the option to fill it at a Wegmans pharmacy if you prefer for the same copay. *Note:* do not submit 30-day prescriptions to OptumRx mail pharmacy because you will be automatically charged the copay applicable to a 90-day supply.

You can pay your copays by check or credit card. If you send in the wrong copay and there is a balance due of less than \$150, an invoice will be included with your prescription order. If you overpaid, your account will be credited. If you owe more than \$150 on your account, your prescription order will not be shipped until payment is made; you will receive a phone call from OptumRx to let you know that this is the case. A way to avoid this situation is to have a credit card number on file with OptumRx. No more than \$500 will be charged to a credit card at one time without your approval. If you have a Beneflex account, you can use the flex card as your credit card for prescription drug orders as long as you have a sufficient balance available. You can join the automatic payment program by calling 1-855-209-1300 or by enrolling online at www.optumrx.com.

To check on the status of an order, you may call OptumRx Member Services or visit www.optumrx.com. You can find out the date your prescription was received, the status of your order, the date your prescription was mailed to you, and other billing and timing data.

If you would like to order online, you can do this through OptumRx mail pharmacy. You can order online anytime, or call 1-855-209-1300 and use the automated telephone system. Or you can mail in your refill orders by using the mail-order envelope. If you order by phone or via OptumRx's website, you will need to provide your member number, found on your OptumRx ID card, and the prescription number found on the medication container and the refill slip.

If you need to order mail-order envelopes or retail claim forms, you can do this online also. Or if you prefer, you can call OptumRx Member Services toll-free number to use the automated telephone system. The requested materials will be mailed to you right away.

Using a Reimbursement Form

If you fill your prescription at a non-participating pharmacy, or forget to bring your ID card to a participating retail 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 reimbursement form to OptumRx to obtain reimbursement of the amount that the prescription drug plan will pay. You can print the reimbursement form from OptumRx's website, or can call Member Services to request a claim form be mailed to you. The receipt you received at the pharmacy must be attached to the claim form. Reimbursement forms must be submitted within 12 months following the date you purchased the medication.

Payment of Benefits

Other than claims submitted using reimbursement forms, benefits will be paid directly to the participating pharmacy dispensing the medication. For claims submitted via reimbursement form, benefits will be paid to you by check from OptumRx.

Medical and Prescription Drug Coverage at Retirement

NOTE REGARDING MEDICARE-ELIGIBLE INDIVIDUALS: As of January 1, 2019, most Medicare-eligible individuals are no longer covered by this Plan. They receive their medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. If eligible, funding is provided by RIT through a Health Reimbursement Arrangement (HRA). A separate Summary Plan Description is provided for the HRA to covered individuals, and is also available on the RIT Human Resources website. Therefore, this SPD is not applicable to Medicare-eligible individuals, other than the small group who are remaining covered by the BlueCross BlueShield Comprehensive plan during 2019. As of January 1, 2020, there will no longer be any Medicare-eligible individuals covered by this Plan.

Eligibility for Retirement

Age, years of service, and date of hire (or adjusted date of hire, if applicable) determines an employee's eligibility for retirement from RIT. The eligibility rules have changed over time and are as follows:

Employees Hired Before January 1, 2019, who

- Were age 45 or older on January 1, 2019 **OR**
- Under age 45 with 10 years of regular full-time service or 15 years of qualifying regular part-time service on January 1, 2019

If adjusted date of hire is prior to July 1, 1990:

- ◆ **Age:** At least 50
- ◆ **Service:** At least 5 years of regular full-time or 10 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

If adjusted date of hire is on or after July 1, 1990 but before January 1, 1995:

- ◆ **Age:** At least 50
- ◆ **Service:** At least 10 years of regular full-time or 15 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

If adjusted date of hire is on or after January 1, 1995:

- ◆ **Age:** At least 55
- ◆ **Service:** At least 10 years of regular full-time or 15 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

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A year of qualifying regular part-time service is a year in which the employee is scheduled to work at least 750 hours. All years of extended part-time service (an employee work classification that existed prior to July 1, 2017) counts as an eligible year of service.

For those who have both regular full-time and qualifying regular part-time service, the following rules apply for counting the Service component:

- ◆ *If the employee meets the Age and Age+Service components and if the employee has at least 5 years of regular full-time service and the regular full-time years of service plus one-half of qualifying regular part-time years of service is at least 10 years, the employee would be eligible to retire with full-time cost sharing.*
- ◆ *If the employee meets the Age and Age+Service components and if the employee has less than 5 years of regular full-time service and the regular full-time years of service plus the qualifying regular part-time years of service is at least 15 years, the employee would be eligible to retire with part-time cost sharing.*

Service must be regular full-time and/or qualifying regular part-time service.

Employees Hired Before January 1, 2019, who

- Were under age 45 on January 1, 2019 **AND**
- Had less than 10 years of regular full-time service or less than 15 years of qualifying regular part-time service on January 1, 2019

Employees Hired On and After January 1, 2019

- ◆ **Age:** At least 62
- ◆ **Service:** At least 15 years of regular full-time or 20 years of qualifying regular part-time service
- ◆ **Age plus Service:** Not applicable

=====

A year of qualifying regular part-time service is a year in which the employee is scheduled to work at least 750 hours. All years of extended part-time service (an employee work classification that existed prior to July 1, 2017) counts as an eligible year of service.

For those who have both regular full-time and qualifying regular part-time service, the following rules apply for counting the Service component:

- ◆ *If the employee meets the eligibility age and if the employee has at least 10 years of regular full-time service and the regular full-time years of service plus one-half of qualifying regular part-time years of service is at least 15 years, the employee would be eligible to retire with full-time cost sharing.*
- ◆ *If the employee meets the eligibility age and if the employee has less than 10 years of regular full-time service and the regular full-time years of service plus the qualifying regular part-time years of service is at least 20 years, the employee would be eligible to retire with part-time cost sharing.*

Service must be regular full-time and/or qualifying regular part-time service.

The following exception applies to all categories of employees listed above:

If, however, the following occurs, eligibility for retiree benefits is modified as described below:

- an individual is an employee (faculty or staff) of RIT; and
- the individual is retirement-eligible; and
- the individual is terminated for cause; and
- the reason for the termination is determined to be the willful misconduct of the employee and excludes actions which are beyond the reasonable control of the individual,

Then:

If the Assistant Vice President-Human Resources (AVP-HR) determines that the person is not a retiree for benefits purposes, then the individual will not be eligible to receive retiree benefits and privileges, effective as soon as administratively practicable on or after the date the determination has been made and communicated to the affected individual.

This is the case whether the willful misconduct occurs before or after the date that the individual retires from RIT – an employee may not elect to retire in advance of the conclusion of an audit or investigation’s final report, with findings submitted to management, in order to avoid discharge and to preserve retiree benefits eligibility.

A committee appointed by the AVP-HR will review the circumstances of the case and provide counsel to the AVP-HR. The AVP-HR will be solely responsible for determining whether the person will be considered a retiree for benefits purposes.

The individual’s eligibility to receive retirement income from the RIT Retirement Savings Plan is not impacted by this determination.

Adding a New Dependent After Retirement

RIT believes it is important to provide access to health care coverage. Dependent eligibility for retirees is the same as for employees, as described in the section “Who is Covered and When” earlier in this summary, with one exception. Any person who becomes an eligible dependent of a retiree may be added to the retiree’s health care coverage through RIT. However, the retiree will be required to pay the full difference in premium for the added individual(s); there will be no financial support from RIT

Example: Martha is retired from RIT and marries Sam. Martha is covered by POS A and chooses to add Sam to her coverage. RIT will continue to pay the amount it had been paying for individual coverage, but Martha will pay the remainder, which includes the additional amount for covering Sam.

Medical Plan Choices in Retirement

If You Retire Before You and Your Spouse/Partner are Eligible for Medicare

If you retire before you (and your spouse/partner) are eligible for Medicare (generally before age 65), you are eligible for the pre-Medicare options that RIT offers active employees (although some plans may not be available due to geographic restrictions) while you (and your spouse/partner) are pre-Medicare. You may enroll in or change medical plans, without waiting periods, at the annual open enrollment period for coverage effective January 1. See the section of this summary that discusses cost sharing to understand the basis for your contributions.

If You Retire When You and Your Spouse/Partner are Eligible for Medicare

When you and your spouse/partner are eligible for Medicare (generally after age 65), you are no longer eligible to be covered by this Plan. You will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, you will need to enroll in Medicare.

Approximately three months prior to turning age 65, or, if you retire after age 65, three months prior to retirement, you should contact your local Social Security office and enroll in Medicare Part A (hospitalization) and Part B (medical). Please note that if you enroll late, you may have higher Part B premiums. The Social Security Administration may require an RIT Human Resources representative to verify your coverage under an employer group plan so you can avoid paying the late enrollment penalty for Part B if your late enrollment is due to your working past your 65th birthday.

If You Retire When You OR Your Spouse/Partner is Eligible for Medicare but the Other is NOT

If either you **OR** your spouse/partner is eligible for Medicare at retirement (i.e., one of you is under age 65 and the other is age 65 or older), the person who is not eligible for Medicare will continue to participate in the same coverage as he/she had prior to retirement (pre-Medicare plan) while pre-Medicare. The one who is eligible for Medicare will enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits; see the section above for more information. You will each have a policy under your own name and identification number. If you are still covering eligible pre-Medicare children, they will be covered under the policy of the pre-Medicare individual and that person will have the appropriate level of coverage (two person or one parent family).

If You Retire When You and Your Spouse/Partner are Eligible for Medicare and You Have a Pre-Medicare Child

If you and your spouse/partner are eligible for Medicare at retirement and you have a pre-Medicare child, you and your spouse/partner will each enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits; see the section above for more information. The pre-Medicare child will continue with

the same coverage you had prior to retirement under an individual policy; if you have more than one child, they will each have an individual pre-Medicare policy.

Cost-Sharing in Retirement

Your contribution toward the cost of your coverage is based upon your cost sharing group, which is determined by your retirement date and age.

The following are the cost-sharing groups with their descriptions. Also referenced for your information are their prior names, which will no longer be used in 2019 and after.

Group 1 (formerly “Grandfathered Retirees):

- Employees who retired before December, 2004, AND who were Medicare-eligible on or before December 31, 2004, and
- Eligible spouses/partners of retirees described above who themselves were Medicare-eligible on or before December 31, 2004, and
- Employees who reached age 65 by June 30, 2005, provided written notice by December 31, 2004 of their intent to retire by June 30, 2005, and did retire by that date.

Note that Group 1 does not include the following: Employees who retired at age 50-59 between April 15, 1986 and June 30, 1996. These individuals are included in Group 2.

Group 2 (formerly “Benchmark Retirees):

- Employees who were hired before January 1, 2004 who were age 35 or older on January 1, 2008, and who retire after December 31, 2004, and
- Employees who retired before December 31, 2004 but were not Medicare-eligible as of December 31, 2004, and
- Eligible spouses/partners of retirees in either Group 1 or Group 2 who themselves were not Medicare-eligible as of December 31, 2004.

Group 3 (formerly “RMA or Retiree Medical Account Retirees):

- Employees who were hired on or after January 1, 2004, and
- Employees hired before January 1, 2004 who were under age 35 on January 1, 2008.
- Eligible spouses/partners/children of Group 3 retirees.

Please note that the RMA was discontinued effective January 1, 2019.

Part-time and Full-time Cost Sharing: If you were an eligible part-time employee during your entire career at RIT, you will pay part-time contributions; if you were a full-time employee during your entire career at RIT, you will pay full-time contributions. If you had a combination of part-time and full-time service, the rules described above regarding eligibility for retirement will determine whether you pay part-time or full-time contributions.

For pre-Medicare Group 2 participants in this Plan, in 2019 your contributions are equal to the contributions charged to employees; your contributions are based upon your cost sharing salary level just prior to your retirement. Beginning in 2020, your contributions will increase by 20% per year beyond the employee contributions; this will continue to increase for 5 years, at which time those in Group 2 will be paying double what the employees are paying. Beginning in 2019, those in Group 3 will be paying 10% more than those in Group 2.

If You Retire and are Later Rehired By RIT – Pre-Medicare

If you are rehired by RIT after retiring, the following rules apply:

- *If you return to RIT as an adjunct or in a regular faculty or staff position that is expected to last less than six months*, you will continue to be covered for medical and prescription drug benefits as a retiree; if your regular faculty or staff employment continues beyond 6 months, your status will be switched to employee for medical and prescription drug benefits and cost sharing.
- *If you are hired in a regular faculty or staff position that is expected to last six months or more*, your medical and prescription drug benefits and cost sharing will be as an employee.

Medical and Prescription Drug Coverage When Approved for RIT Long-Term Disability (LTD)

NOTE REGARDING MEDICARE-ELIGIBLE INDIVIDUALS: As of January 1, 2019, Medicare-eligible LTD recipients and their Medicare-eligible family members are no longer covered by this Plan. They receive their medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. If eligible, funding is provided by RIT through a Health Reimbursement Arrangement (HRA). A separate Summary Plan Description is provided for the HRA to covered individuals, and is also available on the RIT Human Resources website. Therefore, this SPD is not applicable to Medicare-eligible LTD recipients and their Medicare-eligible family members.

Eligibility for LTD Benefits

Regular full-time employees who are approved for long-term disability by RIT's insurance company are eligible for medical and prescription drug coverage under this plan as outlined below. The cost sharing and premium contribution rules are described earlier in this summary.

If your LTD effective date is prior to January 1, 2019, coverage will continue while approved for LTD while pre-Medicare. Coverage under this plan will end

- for you and/or your spouse/partner/child when the individual becomes eligible for Medicare due to a disability or reaching age 65; see the description of "When You Become Eligible for Medicare" in this summary; OR
- when RIT's LTD insurance company determines that you are no longer eligible for LTD if you were not eligible for retirement from RIT on your LTD effective date.

When your LTD ends and you were eligible for RIT retirement on your LTD effective date, you (if you are pre-Medicare) and your eligible pre-Medicare family members would be eligible to continue coverage under this plan while pre-Medicare under the retiree rules described above.

If your LTD effective date is in 2019 or after, coverage will continue while approved for LTD for up to two years from the LTD effective date while pre-Medicare. Coverage under this plan will end before two years has elapsed

- for you and/or your spouse/partner/child when the individual becomes eligible for Medicare due to a disability or reaching age 65; see the description of "when You Become Eligible for Medicare" in this summary; OR
- when RIT's LTD insurance company determines that you are no longer eligible for LTD if you were not eligible for retirement from RIT on your LTD effective date.

When you reach the two year benefits continuation maximum and you were eligible for RIT retirement on your LTD effective date, you (if you are pre-Medicare) and your eligible pre-Medicare family members would be eligible to continue coverage while pre-Medicare under the retiree rules described above.

If your LTD ends before the two year benefit continuation maximum and you were eligible for RIT retirement on your LTD effective date, you (if you are pre-Medicare) and your eligible pre-Medicare family members would be eligible to continue coverage while pre-Medicare under the retiree rules described above.

When You Die While You and/or Your Family Members are Covered Under This Plan

Coverage continuation for your eligible survivors is based on multiple factors and is described below.

Upon Your Death if You are Retired or an Employee or LTD Recipient Who is Eligible to Retire

If you are retired at the time of your death, RIT continues coverage for your pre-Medicare spouse/partner (who was your spouse or partner at the time of your retirement from RIT) and any eligible pre-Medicare child (who was your eligible child at the time of your retirement from RIT) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements. When your spouse/partner and/or child becomes eligible for Medicare, coverage, they are no longer eligible to be covered by this Plan. They will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, they will need to enroll in Medicare.

If you die while employed at RIT and are retirement-eligible at the time of your death, RIT continues coverage for your pre-Medicare spouse/partner (who was your spouse or partner at the time of your death) and any eligible pre-Medicare child (who was your eligible child at the time of your death) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements. When your spouse/partner and/or child becomes eligible for Medicare, coverage, they are no longer eligible to be covered by this Plan. They will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, they will need to enroll in Medicare.

If you die while on RIT long-term disability (LTD) and you were retirement-eligible at the time your LTD was effective, RIT continues coverage for your pre-Medicare spouse/partner (who was your spouse or partner at the time of your death) and any eligible pre-Medicare child (who was your eligible child at the time of your death) at the appropriate level of coverage with the cost sharing rules in effect for retirees in your category. Coverage for your surviving spouse/partner will end if he/she becomes married/partnered. Coverage for your surviving child will end when he/she no longer meets the Plan's eligibility requirements. When your spouse/partner and/or child becomes eligible for Medicare, coverage, they are no longer eligible to be covered by this Plan. They will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, they will need to enroll in Medicare.

Upon Your Death On or After January 1, 2019 if You are Not Eligible to Retire

The following rules are in effect for the death of an individual who was not retirement eligible that occurs on or after January 1, 2019:

If you die while employed at RIT and are not retirement eligible at the time of your death, your eligible pre-Medicare family members will be offered continuation of coverage under COBRA. If COBRA is elected, RIT will subsidize the COBRA premium for the first six months so the survivor is paying the same amount the employee would have paid for the same level of coverage.

If you die while on RIT long-term disability (LTD) and were not retirement-eligible at the time your LTD was effective, your eligible pre-Medicare family members will be offered continuation of coverage under COBRA. If COBRA is elected, RIT will subsidize the COBRA premium for the first six months so the survivor is paying the same amount the employee would have paid for the same level of coverage.

Refer to the section in this summary titled “When You are Eligible for COBRA.”

If You are the Survivor of an Employee or LTD Recipient Who Died Prior to January 1, 2019 Who Was Not Eligible to Retire

The following rules are in effect for the death of an individual who was not retirement eligible that occurred before January 1, 2019:

Upon the death of an employee or RIT long-term disability recipient who was not retirement eligible and would have been in cost sharing Group 2 at the time of death, RIT continues coverage for the pre-Medicare spouse/partner (who was the spouse or partner at the time of death) and any eligible pre-Medicare child (who was an eligible child at the time of death) at the appropriate level of coverage with the Group 2 cost sharing for retirees. Coverage for the surviving spouse/partner will end if he/she becomes married/partnered. Coverage for a surviving child will end when they no longer meet the Plan’s eligibility requirements. When the spouse/partner and/or child becomes eligible for Medicare, coverage, they are no longer eligible to be covered by this Plan. They will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, they will need to enroll in Medicare.

Upon the death of an employee or RIT long-term disability recipient who was not retirement eligible and would have been in cost sharing Group 3 at the time of death, RIT continues coverage for the pre-Medicare spouse/partner (who was the spouse or partner at the time of your death) and any eligible pre-Medicare child (who was an eligible child at the time of death) at the appropriate level of coverage for up to three years following the death at the regular employee contribution amount. After three years, they can continue to participate by paying the full premium. Coverage for the surviving spouse/partner will end if he/she becomes married/partnered. Coverage for the surviving child will end when he/she no longer meets the Plan’s eligibility requirements. When the spouse/partner and/or child becomes eligible for Medicare, coverage, they are no longer eligible to be covered by this Plan. They will need to enroll in medical and prescription drug coverage through a private Medicare Exchange, Via Benefits. Contact information for Via Benefits will be provided to you by RIT Human Resources, or is available on our website. But first, they will need to enroll in Medicare.

Cancelling Coverage for Non-Payment

RIT’s outside administrator, Lifetime Benefit Solutions (LBS), bills employees who are on an unpaid leave of absence or whose pay is too small to take payroll deductions, LTD recipients whose LTD payment is too small to take the deduction, and pre-Medicare retirees/spouses/partners/survivors, for the applicable contributions.

There is a grace period before coverage is cancelled for non-payment. If LBS does not receive the full premium amount by the last day of the second month, coverage will be cancelled as of the last day of the second month. For example:

- March 11 LBS issues bill for April coverage
- April 1 Payment is due for April coverage
- April 5 LBS sends a reminder notice for April coverage if not paid
- April 11 LBS issues bill for May coverage; bill includes April premium if not paid

May 1	Payment is due for May coverage
May 31	Coverage is cancelled effective May 31 if payment for April coverage is not received

The first time coverage is cancelled for non-payment, there is a three-month waiting period before you can re-enroll in coverage; coverage will not be retroactive. Before you can re-enroll, you must pay the outstanding balance owed as well as the premium for the first month's coverage. Payment must be with a cashier's or bank check, electronic funds transfer (EFT) from your bank account, money order, or credit card.

If coverage is cancelled again for non-payment, there is a six-month waiting period before you can re-enroll in coverage; coverage will not be retroactive. Before you can re-enroll, you must pay the outstanding balance owed as well as the premium for the first month's coverage. Payment must be with a cashier's or bank check, electronic funds transfer (EFT) from your bank account, money order, or credit card.

When Coverage Ends

Your employee medical and prescription drug coverage under this plan ends the last day of the month in which

- Your employment ends*;
- You are an adjunct employee and you are not working for RIT;
- You are a less than 9-month employee and you are not working for RIT;
- Your employment ends under the RIT Severance Plan (coverage does not continue during the severance period, unless you elect coverage under COBRA);
- You retire from RIT and you (or your spouse/partner/child) are eligible for Medicare retiree coverage, the pre-Medicare coverage ends on the last day of the month in which you retire for the Medicare-eligible individual(s). Enrollment would then be under the private Medicare Exchange, Via Benefits (see information in this summary for Medicare-eligible individuals);
- Your long-term disability benefits end and you are not eligible to retire from RIT;
- You no longer meet the Plan's eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan;
- You stop making required contributions;
- You die; or
- RIT discontinues the Plan.

* *Special Note for 9-month faculty:*

- *Coverage will end on June 30 for a faculty member on a 9-month contract, provided that the faculty member works until the end of the contract period, and the contract is not being renewed for the following academic year;*
- *Coverage for a faculty member on a 9-month contract will continue during the summer between the two academic years, provided that the contract is being renewed for the following academic year.*

If you are retired, your medical and prescription drug coverage under this plan ends the last day of the month

- before Medicare coverage is effective. Medicare is generally effective the first day of the month in which you reach age 65, but if your birthday is on the first of the month, it will be the first of the prior month. When you become eligible for Medicare, you would be eligible for coverage under the private Medicare Exchange, Via Benefits (see information in this summary for Medicare-eligible individuals);
- you stop making required contributions;
- you die; or
- RIT discontinues the Plan.

If you are a long-term disability recipient under RIT's LTD plan and your LTD effective date was before January 1, 2019, your medical and prescription drug coverage under this plan ends the earliest of

- the last day of the month before Medicare coverage is effective;
- the last day of the month in which your LTD benefits end and you are not retirement eligible;
- you stop making required contributions;
- you die; or
- RIT discontinues the Plan.

If you are a long-term disability recipient under RIT's LTD plan and your LTD effective date was on or after January 1, 2019, your medical and prescription drug coverage under this plan ends the earliest of

- the last day of the month that is two years from the date your LTD became effective;
- the last day of the month in which your LTD benefits end and you are not retirement eligible;
- last day of the month before your Medicare coverage is effective;
- you stop making required contributions;
- you die;
- RIT discontinues the Plan.

Generally, your dependent's coverage ends when your coverage ends, except when you are retired or receiving LTD benefits and you or your spouse/partner/child becomes eligible for Medicare. The coverage rules for your Medicare-eligible spouse/partner/child are the same as for you as outlined above. However, a child's coverage would also end on the last day of the month in which he or she no longer meets the Plan's eligibility.

If you are a surviving spouse/partner/child, your medical and prescription drug coverage under this plan ends the earliest of

- the last day of the month before Medicare coverage is effective;
- you stop making required contributions;
- you remarry/re-partner (for the spouse/partner);
- you reach the age limit of the plan (for a child);
- you die;
- RIT discontinues the Plan.

If it is determined that you or an eligible family member has submitted a fraudulent claim or fraudulent proof of eligibility, or has intentionally misrepresented any facts under a medical, prescription drug, vision or dental plan, you and all your dependents will be permanently ineligible for coverage under the RIT Medical and Prescription Drug Plan, the RIT Retiree-Only Health Reimbursement Arrangement Plan, the RIT Vision Care Plan, and the RIT Dental Care Plan.

Coverage May Be Continued

In certain circumstances, your coverage and that of your dependents may be continued beyond the date it normally would end. Coverage may continue as shown below, provided you make any required premium contributions.

- For a Disabled Child - Coverage for an unmarried child who is physically or mentally incapable of self-support and who reached age 26 prior to 2019 may be continued beyond the age limit of the plan provided the disability occurred before that age and family coverage under this plan was in effect before the disability occurred. For a child reaching age 26 in 2019 or after, benefits will end the last day of the month in which the child reaches age 26.

- For a Personal Leave of Absence – Coverage may continue while on a personal leave of absence of up to four months. For personal leaves of absence beyond four months, coverage is not continued.
- For a Professional Leave of Absence - Coverage is continued for up to two years while on an approved professional leave of absence, including a sabbatical. For professional leaves of absence beyond two years, coverage is not continued.

When You Are Eligible for COBRA

The following contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This information explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of the coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your eligible children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, spouse, or eligible child, you will become a qualified beneficiary if an employee loses coverage. An eligible employee, covered spouse or covered eligible child are entitled to an additional 18 months of coverage under the Plan because one of the following qualifying events happen:

- You no longer meet the Plan’s eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan;
- Your approved leave of absence ends (e.g., personal, professional, Family and Medical Leave Act, New York State Paid Family Leave) and you do not return to work; or
- Your approved leave of absence continues, but the maximum benefits continuation period is reached (i.e., coverage ends); or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage. You are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your eligible children will become qualified beneficiaries if they lose coverage. They are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an eligible child.

Note regarding domestic partners and their children: Under federal law, the domestic partner and/or children of a domestic partner are not considered qualified beneficiaries. However, RIT does extend continuing coverage to these individuals as though they were COBRA-eligible.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Rochester Institute of Technology, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and eligible children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA administrator of the following qualifying events:

- the end of employment or change in employment or benefits eligibility;
- death of the employee;
- commencement of a proceeding in bankruptcy with respect to the employer; or
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you must notify RIT Human Resources in writing within 60 days after the qualifying event occurs. The employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice of the qualifying event should be sent to RIT Human Resources, at the address provided at the end of this summary, and should include the following information:

- Request Date (month/day/year)
- Employee Name
- Employee ID Number
- Name of person losing coverage
- Relationship to employee
- Address for person losing coverage
- Reason for loss of coverage (additional documentation may be requested)
- Date coverage was lost (month/day/year)

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or the employee becoming ineligible for coverage. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage; these events include the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or an eligible child's losing eligibility as an eligible child.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and eligible children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any eligible children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the eligible child stops being eligible under the Plan as an eligible child. This extension is only available if the second qualifying event would have caused the spouse or eligible child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Paying for Continuation Coverage

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium.

For disability extensions up to 29 months if an individual is determined to be disabled (for Social Security disability purposes) Rochester Institute of Technology reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

Grace period for monthly payments

Although monthly payments are due on the first day of each month of COBRA coverage, COBRA participants will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for

each month as long as payment is made before the end of the grace period for that payment, but coverage is subject to being suspended as explained below.

If payment is made after the due date but before the end of the 30-day grace period for that month, health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim(s) submitted for reimbursement while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Termination of Continuation Coverage

The law also provides that your continuation coverage may be terminated for any of the following five reasons:

1. Rochester Institute of Technology no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

If You Have Questions

If you have questions, contact your benefits representative in the Human Resources Department. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information for return of COBRA Election Forms and Premium Payments:

P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202
Attn: RIT COBRA

Written notice is considered to have been made on the date the notice is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office.

All notices must include: the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Receive a summary of the plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or eligible children if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan of the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Orders ("QMCSOS")

A medical child support order shall be filed with the plan administrator as soon as reasonably possible after it has been filed promptly upon the receipt of such order, the plan administrator shall notify the participant and each person eligible to receive benefits under the terms of the order ("alternate recipients") of its receipt and of the procedures set forth in this section 14.04.

The Participant and the alternate recipients may provide comments to the Plan Administrator with respect to the order during the 30 day period commencing as of the date the Plan Administrator sends them notice of receipt of the order. The Plan Administrator shall, within the 60 day period commencing as of the expiration of the 30 day comment period specified in the preceding sentence, determine whether the order is qualified and shall so notify the participant and the alternate recipients in writing of its decision. The parties may waive the 30 day comment period. If they do so, the 60 day period shall commence as of the date all parties have waived their rights to submit comments. The Plan Administrator's determination on the qualified status of an order is final. As soon as reasonably practicable following its notification that an order is "qualified," the Plan Administrator shall take such steps it deems appropriate to implement the order.

The Plan Administrator encourages parties to submit draft orders for "pre-approval" of their qualified status prior to their being submitted to a court for signature as such pre-approval will expedite approval procedures.

An alternate recipient may designate a representative for receipt of copies of notices that are sent to an alternate recipient with respect to a medical child support order.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

- Penalizing or otherwise reducing or limiting the reimbursement of an attending physician for the required care;
- Providing any incentive (monetary or otherwise) to induce the attending physician to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, copayments, and coinsurance provisions that apply to similar benefits.

Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

In New York State, find information as follows:

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

Most other states do offer premium assistance programs; contact your state directly. For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Notice of Privacy Practices

This Notice describes how some of the Rochester Institute of Technology (the “Plan Sponsor”) employee benefit plans administered by our carriers, vendors and/or any third-party administrator (collectively referred to in this notice as the “Plan,” “we,” “us,” or “our”), may use and disclose Protected Health Information, as defined below, to carry out payment and health care operations, and for other purposes that are permitted or required by law. The plans covered by these regulations are RIT’s Medical Care and Prescription Drug Plan, Retiree-Only Health Reimbursement Arrangement Plan, Dental Care Plan, Vision Care Plan, Beneflex and Employee Assistance Program.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide individuals covered under the Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be provided to all participants in the Plan. Copies of RIT’s current Notice may be obtained by using the contact information below, or can be found on RIT’s HR website at <http://www.rit.edu/benefits>.

Protected Health Information (“PHI”) means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Uses And Disclosures Of Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – We will not use or disclose your PHI for marketing purposes or sell your PHI unless you have signed a written authorization. Additionally, any other uses or disclosures not described in this Notice will be made only after you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that (1) we have taken action in reliance upon the authorization or (2) the authorization was obtained as a condition of obtaining coverage under the Plan and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – There may be requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, information regarding your medical procedures and treatment may be used to process and pay claims. Your PHI may also be disclosed for the payment of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – Your PHI may be used as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to the Plan.

Treatment – Although the law allows use and disclosure of your PHI for purposes of treatment, as a group health plan, your information generally does not need to be disclosed for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your PHI for purposes of treatment, payment and health care operations.

Family and Friends Involved in Your Care – If you are available and do not object, your PHI may be disclosed to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and it is determined that a limited disclosure is in your best interest, limited PHI may be shared with such individuals. For example, the Plan's claims administrator may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits under the Plan. Examples of these outside persons and organizations might include vendors that process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. Business Associates are also required by law to protect PHI.

Plan Sponsor – PHI may be disclosed to certain employees of the Plan Sponsor for the purpose of administering the Plan. These employees will use or disclose the PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other Uses and Disclosures – There are certain other lawful uses and disclosures of your PHI without your authorization. Disclosures are allowed

- for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence, your PHI may be disclosed to the proper authorities.
- if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- for law enforcement purposes, your PHI may be disclosed to the proper authorities.
- to coroners, medical examiners, and/or funeral directors consistent with law.
- for cadaveric organ, eye or tissue donation.
- for research purposes, but only as permitted by law.
- to avert a serious threat to health or safety.
- if you are a member of the military as required by armed forces services, and for other specialized government functions such as national security or intelligence activities.
- to workers' compensation agencies for your workers' compensation benefit determination.
- if required by law, your PHI will be released to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, uses or disclosure of your PHI will be restricted in accordance with the more stringent standard.

Rights That You Have

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. You have the right to request that we send a copy of your PHI that we maintain in designated record sets to another person. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI or that you want your PHI sent to another person (who must be named in the request), and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that your PHI not be disclosed to your spouse. Your request must describe in detail the restriction you are requesting. Your request will be considered, but in most cases there is no legal obligation to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations and the PHI pertains solely to a health care item or service that you have paid for out-of-pocket and in full. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to be Notified of a Breach – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

Right to a Copy of the Notice – If you have agreed to accept this Notice electronically, you have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health

and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

For Further Information

If you have questions or need further assistance regarding this Notice, you may contact your benefits representative in RIT's Human Resources Department. The mailing address is 8 Lomb Memorial Dr., Rochester, NY 14623.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to apply for medical coverage with Rochester Institute of Technology (RIT). You should read this information even if you waive coverage.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the RIT medical coverage if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must contact RIT Human Resources and request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the RIT medical coverage. However, you must contact RIT Human Resources and request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment in RIT medical coverage for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in an RIT medical plan if you or your dependents lose eligibility for that other coverage. However, you must contact RIT Human Resources and request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage, you may be able to enroll yourself and your dependents in that plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request a special enrollment or obtain more information, feel free to contact the Human Resources Department.

Administrative Claim Procedures

Claims concerning eligibility, participation, contributions, or other aspects of the operation of the Plan should be in writing and directed to the Plan Administrator; this section does not apply to claims for benefits or services under the Plan because all claim decisions are made by the Plan's third party administrator, Excellus BlueCross BlueShield, to whom RIT has delegated this responsibility. The Plan Administrator will generally notify you of its decision within 90 days after it receives your claim.

However, if the Plan Administrator determines that special circumstances require an extension of time to decide your claim, the Plan Administrator may obtain an additional 90 days to decide the claim. Before obtaining this

extension, the Plan Administrator will notify you, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If your claim is denied in whole or in part, the Plan Administrator will provide you with a written or electronic notice that explains the reason or reasons for the decision, including specific references to Plan provisions upon which the decision is based, a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information may be necessary), a description of the appeals procedures and applicable filing deadlines and your right to bring an action under Section 502(a) of ERISA.

If you disagree with the decision reached by the Plan Administrator, you may submit a written appeal to the Plan Administrator requesting a review of the decision. Your written appeal must be submitted within 60 days of receiving the Plan Administrator's decision and should clearly state why you disagree with the Plan Administrator's decision. You may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access to and copies of all documents, records and other information relevant to the claim.

The Plan Administrator will generally decide your appeal within 60 days after it is received. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 60 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify you, in writing and before the end of the initial 60-day period, of the special circumstances requiring the extension and the date by which it expects to render a decision.

The Plan Administrator will provide you with written or electronic notice of its decision. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that you are entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. Additionally, the notice will include a statement regarding your right to bring an action under Section 502(a) of ERISA. Generally, you must exhaust your internal administrative appeal rights before you can bring a legal action against the Plan. The Plan Administrator has full discretionary power to construe and interpret the Plan and its decisions are final and binding on all parties.

Important Information about the Plan

Employer	Rochester Institute of Technology
Employer Identification Number:	16-0743140
Plan Sponsor:	Rochester Institute of Technology 8 Lomb Memorial Drive Rochester, NY 14623 (585) 475-2424
Plan Name:	RIT's Group Health Insurance Plan
Plan Number:	501
Plan Year:	January 1 - December 31
Plan Administrator:	Associate Director Human Resources, Benefits Rochester Institute of Technology 8 Lomb Memorial Drive Rochester, NY 14623 (585) 475-2424
Agent for Service of Legal Process:	Office of Legal Affairs Rochester Institute of Technology 154 Lomb Memorial Drive Rochester, New York 14623-5608

Service of legal process may also be made on the Plan Administrator.

The Affordable Care Act ("ACA"), also called Health Care Reform, generally requires large employers such as RIT to offer medical coverage beginning in 2015 to employees who are "full-time," as defined by the law. Under the ACA, full-time is currently defined as an employee who works an average of 30 hours or more per week during a 12-month "measurement period." For determining eligibility for employees who are *not* regular full-time or part-time (those already eligible for RIT medical coverage), the following are the annual dates that RIT has defined for ACA purposes.

Measurement Period	October 15-October 14
Administrative Period	October 15-December 31
Stability Period	January 1-December 31