2010 Benefits Enrollment SUPPLEMENT

Human Resources ■ Finance & Administration

FOR PRE-MEDICARE RETIREES

October 2009

RIT INTRODUCES NEW LOW CONTRIBUTION MEDICAL PLAN: POS C

When it comes to improving RIT's medical benefits, one consistent message we hear from employees and retirees is the desire to have a low contribution medical plan alternative that includes prescription drug coverage. Although the POS B No Drug Plan offers a low contribution option, we've been told it is not a realistic choice for people who take medications, or for those who do not want to risk being without prescription drug coverage, in the event of an unexpected costly medication need.

In response, RIT is introducing an additional medical option for 2010: **POS C**. POS C includes a prescription drug plan, but it is different than the existing prescription drug plan provided by RIT (see details on page 6).

With the new POS C medical plan, you pay significantly less in plan contributions, compared with RIT's POS A and POS B options, and generally more at the time of service (until you reach the plan's annual deductible and out-of-pocket maximum amounts). It is important to clearly understand the differences between these plan options before you elect your medical coverage for 2010.

How the Plan Works

Like RIT's current POS A and POS B plans, the new POS C plan has different benefit levels, depending on whether you receive medical services from providers within the Excellus BlueCross BlueShield's Blue Point2 network ("in-network benefits"), or you receive care from non-participating providers ("out-of-network benefits"). You are required to have a primary care physician (PCP), and your PCP coordinates your care. While most specialties do not require referrals any longer, there are still some that do. Check with Excellus BlueCross BlueShield if you have questions about whether a particular specialty requires referrals from your PCP.

What's different about the POS C plan is ***when*** and ***how much*** you pay for coverage. Unlike RIT's current medical plans that require you to pay small, flat copays at time of service, but higher contributions throughout the year (whether you receive medical services or not), POS C requires participants to pay ***less in plan contributions and sometimes pay more at the time of service***. Although you may pay more towards the actual cost of services, with POS C, your annual out-of-pocket costs are limited through the plan's annual deductible and out-of-pocket maximum features (refer to pages 3 – 5). So even if you were to experience a severe and costly medical illness or injury, you would be protected from overwhelming financial expenses (see example beginning on page 8).

Key POS C plan features are described in the "POS C At-A-Glance Plan Summary" chart on page 2.

A+ Employer

Rochester Institute of Technology
Department of Human Resources
George Eastman Building
8 Lomb Memorial Drive
Rochester, New York 14623-5604

POS C AT-A-GLANCE PLAN SUMMARY

Select a PCP	Yes
Referrals Required	Only for a small number of specialties
Out-of-Network Coverage	Yes, at a lower coverage level*
Retiree Contributions	Lower than POS A and POS B, slightly higher than POS B No Drug
Annual Medical Deductible**	
Single Two-Person Family (see examples on page 3)	$300 $300 per individual $750 combined family total
Medical Coinsurance (Amount covered by the plan after deductible has been met)	Plan pays 80%; you pay 20%
Annual Medical Out-of-Pocket Maximum**	
Single Two-Person Family	$2,500 $2,500 per individual $6,250 combined family total
Coverage After Medical Out-of-Pocket Maximum is Met	Plan pays 100% of the cost of covered medical services for remainder of plan year (excludes preventive care and prescription drug expenses)
Preventive Care – Medical (Annual physical examination; routine screenings such as mammography, colonoscopy, Pap smear, cholesterol testing, etc.)	$30/35 copay (at PCP/specialist), does not apply toward medical deductible or out-of-pocket maximum $0 copay for well child care

Prescription Drugs

		Coverage After Rx Annual Deductible Has Been Met		
Copays	**Annual Deductible**	**RETAIL 30-day supply up to 3 fills**	**RETAIL 30-day supply after 3 fills**	**MEDCO BY MAIL 90-day supply**
Tier 1: Generic Drugs	Each person must pay the $250 annual deductible before copayment amounts are charged; drugs in all 3 tiers count toward this deductible.	$ 10	$ 25	$ 25
Tier 2: Brand Name Formulary Drugs		$ 50	$125	$125
Tier 3: Brand Name Non-Formulary Drugs		$100	$250	$250
NOTE: There is no out-of-pocket maximum for prescription drug expenses.				

IMPORTANT NOTE:
Medical benefits and prescription drug benefits are entirely separate under POS C, just as they are with POS A and POS B. The medical portion of the plan is administered by Excellus BlueCross BlueShield. The prescription drug portion is administered by Medco. You will receive two separate ID cards. Keep this in mind as you read the following summary. It will help you understand why there are separate features for medical versus prescription drug benefits.

**See Medical Benefits Comparison Book for description of out-of-network coverage.*

***Preventive care copays, prescription drug expenses, out-of-network expenses, amounts over reasonable and customary costs and ineligible expenses do not count toward your out-of-pocket maximum or your deductible.*

POS C Plan
Terms to Know

Medical Deductible

Most medical services under POS C are subject to an **annual deductible**. This means, each calendar year, you need to pay the full cost of non-preventive in-network expenses until you have paid the individual annual deductible amount of $300.

EXAMPLE: If you visit your primary care physician in January for an illness, and have not yet had any other medical expenses in the year, you will pay the full allowed charge for the office visit. So if the allowed charge is $70, you will pay $70.

Two-Person Coverage

If you have two-person coverage, each covered person has his/her own $300 individual deductible to meet before the coinsurance (see description to right) begins, except for preventive care services. Once a person has paid the $300 deductible, coinsurance will begin for that individual.

EXAMPLE: If you have a two-person plan for you and your spouse and you meet the $300 deductible, you do not have to wait for your spouse to meet his or her $300 deductible before your coinsurance begins. Your spouse's coinsurance will begin once he or she meets the individual deductible independently.

Family Coverage

If you have family coverage for three or more eligible family members, a special combined deductible feature applies. This means, once your family's combined total eligible expenses meet the family annual deductible amount of $750, each covered family member will be considered to have met his/her individual deductible and the coinsurance (see description to right) will begin for all family members.

Here's how it works: Each family member pays, at most, $300 in out-of-pocket medical expenses that applies toward the $750 family deductible. If an individual family member meets his/her $300 individual annual deductible, coinsurance (see description below) begins for that family member only. Once the combined sum of eligible expenses paid by family members equals $750, then the family deductible is met and the coinsurance applies for ***all*** covered family members, regardless of whether any or all members have met the $300 individual deductible.

EXAMPLE: Consider a family plan with three members: John, Sue and Nancy. By the end of March, John paid $300 in out-of-pocket medical expenses, reaching his individual deductible. Sue paid $250 in out-of-pocket costs and Nancy paid $100 for medical expenses. As a result, a total of $650 was applied toward the family deductible (John - $300, Sue - $250, Nancy - $100). Because John had reached his annual deductible, his coinsurance (see description below) began at the end of March. However, Sue and Nancy had to continue to pay for another $100 in medical expenses (combined) before the $750 family deductible was met and they could be eligible for coinsurance too.

Coinsurance

Once you meet the annual plan deductible, most covered services for the rest of the year are paid through a cost-sharing arrangement known as **coinsurance**. Your in-network coinsurance is 20%. This means, once you meet your $300 individual deductible, the plan pays 80% of the cost for covered expenses within the Excellus Blue Point2 network (the same network as POS A and B) and you only pay 20% for the remainder of the year until you reach your out-of-pocket maximum (see description on next page).

EXAMPLE: If you have met your deductible (but not your out-of-pocket maximum), and you have a doctor's office visit (due to illness) that cost $70, you will pay only $14 (20% of $70) and the plan will pay the remaining $56.

Preventive Care Services

To encourage preventive care, you pay a flat copay amount for **preventive care services** at the time of service, similar to our current POS A and POS B plans. Preventive care copays cannot be applied toward your annual medical deductible or out-of-pocket maximum (see description below). Preventive care services include routine physical examinations and annual checkups for adults, age-appropriate immunizations, as well as routine screenings such as mammography, colonoscopy, prostate cancer screening, cholesterol screening, routine annual gynecologist visit and Pap smears, and eye exams. It is important to note, a service is not considered preventive care when provided as part of a diagnostic or treatment plan; if this is the case, then the service is not paid with a copay and is subject to the deductible and coinsurance.

EXAMPLE: When you go for a routine annual checkup, and the cost is $70, you will only pay the $30 copay; regardless of whether you have met your annual deductible.

Well child visits, including immunizations, are covered in full, ***with no copay and no out-of-pocket costs***, and cannot be applied toward the annual medical deductible or out-of-pocket maximum (see description below).

Out-of-Pocket Maximum

The POS C "out-of-pocket maximum" feature provides important protection against financial loss from catastrophic expenses. When a person has high medical expenses during the year, once they reach the out-of-pocket maximum, his/her additional eligible medical expenses (not including preventive care or prescription drug expenses) will be covered at 100% for the remainder of the year. ***The out-of-pocket maximum is a set dollar amount ($2,500 per individual/$6,250 per family) and is the most you will pay for most covered medical expenses in a calendar year before the plan begins paying 100% of the cost of covered expenses***. Eligible medical expenses that apply toward your medical deductible, and for which you pay coinsurance, are applied toward your out-of-pocket maximum. Preventive care copays, prescription drug expenses, out-of-network expenses, amounts over reasonable and customary costs and ineligible expenses do not count toward your out-of-pocket maximum or your annual deductible.

Family Coverage

If you have family coverage for three or more eligible family members, a special ***combined out-of-pocket maximum*** feature applies, similar to the combined family deductible feature. This means, once your family's combined total medical costs meet the family out-of-pocket maximum amount of $6,250, each covered family member will be considered to have met his/her out-of-pocket maximum, and the plan will pay 100% of most family members' covered medical expenses for the remainder of the year. This feature gives your family even greater financial protection in the rare event that more than one covered family member has significant medical expenses during the year.

Here's how it works: Each family member pays, at most, $2,500 out-of-pocket for eligible medical expenses that applies toward the $6,250 family deductible. If an individual family member meets his/her $2,500 individual out-of-pocket maximum, the plan begins paying 100% of eligible medical expenses for that family member only. Once the combined sum of eligible out-of-pocket expenses paid by family members is more than $6,250 total, then the family deductible is met and the plan begins paying 100% of eligible medical expenses for ***all*** covered family members, regardless of whether or not all (or any) members have met the $2,500 individual deductible.

EXAMPLE: Consider a family plan with three members: John, Sue and Nancy. By the end of June, John had $10,000 in medical expenses, Sue had $4,000, and Nancy had $2,000. Because the individual out-of-pocket maximum is $2,500, both John and Sue reached the out-of-pocket maximum and were able to apply $5,000 total toward the family out-of-pocket maximum of $6,250 ($2,500 each). As a result, the balance of their combined expenses to-date (John - $7,500 and Sue - $1,500), and any additional eligible medical expenses incurred through the remainder of the year would be covered at 100% by the plan.

Since Nancy had $2,000 in expenses, and only an additional $1,250 was needed to reach the family out-of-pocket maximum ($6,250 - $5,000 = $1,250), only this portion of Nancy's total expenses to-date was applied to the family out-of-pocket maximum, enabling it to be reached. As a result, the balance of Nancy's covered expenses ($750) along with any additional covered expenses she incurs through the remainder of the year would be covered at 100% by the plan. So no matter how much additional covered medical expenses this family incurs throughout the year, they will never pay more than $6,250 total in out-of-pocket costs (except ineligible expenses identified on page 9).

COVERAGE FOR OUT-OF-NETWORK MEDICAL SERVICES

Like Blue Point2 POS A and POS B plans, the new POS C also offers reduced benefits coverage for out-of-network services.

When services are rendered from physicians, hospitals and other medical providers who are not part of Excellus BlueCross BlueShield's 31-county network, or if required referrals are not obtained, these services will be considered out-of-network. For out-of-network care, a separate, higher deductible applies and once the deductible is met, the coinsurance you pay is 30% of the reasonable and customary amount (the plan pays 70%).

The reasonable and customary (R&C) amount of an out-of-network claim is based on the typical cost for treatment, services or supplies for similar conditions in your geographic area, as determined by Excellus. The R&C amount may be different from the amount charged by a particular provider, and you are responsible for paying the full cost of any amount charged that is over the R&C amount. There is also a separate, higher out-of-pocket maximum for out-of-network services. Your in-network expenses ***do*** count toward the out-of-network, out-of-pocket maximum, but out-of-network expenses ***do not*** count toward the in-network, out-of-pocket maximum. If you reach the out-of-network, out-of-pocket maximum, then eligible expenses will be covered at 100% of the R&C amount for the remainder of the year. However, if an out-of-network provider charges more than the reasonable and customary amount, you are required to pay the difference. Amounts over R&C do not count toward the out-of-network, out-of-pocket maximum. See the Medical Benefits Comparison Book for details concerning out-of-network benefits.

POS C Prescription Drug Coverage

The prescription drug portion of the POS C plan has an **annual Rx deductible** ($250), which is separate from the medical deductible. Covered drug expenses are applied toward the Rx deductible (but *not* toward the annual medical deductible, which is separate). Once the Rx deductible is met, you will pay flat **copay** amounts for your medications for the remainder of the plan year (see POS C At-A-Glance Summary chart on page 2). This means you will pay the first $250 of prescription drug expenses each year, but then you will only pay the copays (or the actual cost of the drug, if it is lower than the copay amount) for the remainder of the year when you purchase your medications at a retail pharmacy or through Medco By Mail.

If you take advantage of any of the retail pharmacy special generic programs, such as those offered by Wegmans and Wal-Mart, the amounts you pay for your medications under those programs will only count toward your deductible if:

- You purchase a 30-day supply (since the plan excludes a larger day supply purchased at a retail pharmacy); and
- You show your Medco identification card at the pharmacy.

The prescription drug copays shown on page 2, on the POS C At-A-Glance Plan Summary chart, apply for the remainder of the calendar year once you have met your annual Rx deductible.

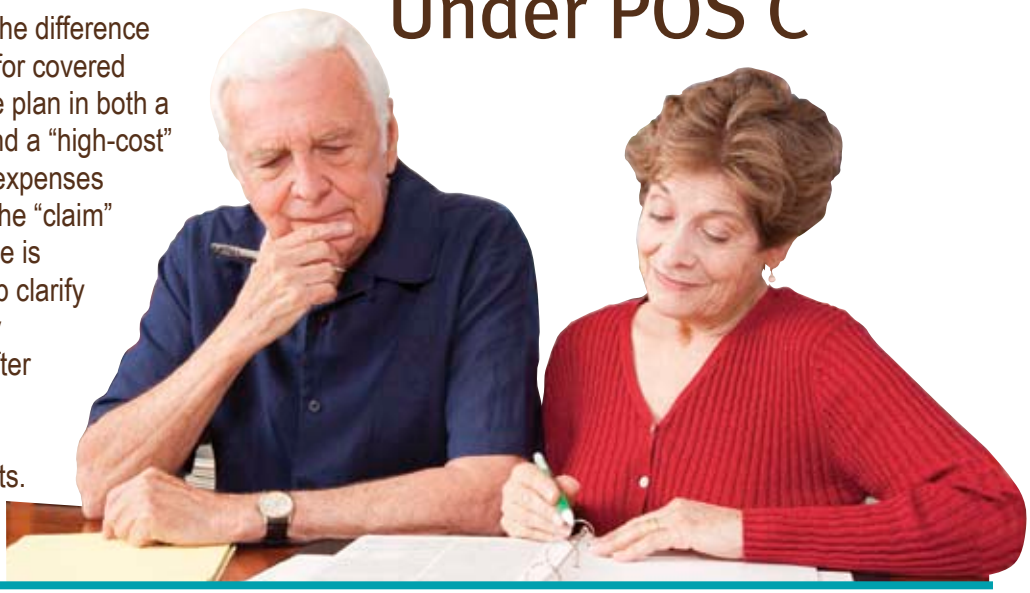
All other rules and processes that apply to the current RIT Rx plan will also apply to this new prescription drug plan. For detailed information, see the summary plan description of the current RIT Rx plan on the HR website at **http://finweb.rit.edu/humanresources/benefits/healthy/prescriptionplan.html#5a**, and the article "Reminders About Medco by Mail" on page 11.

Unlike with medical coverage, there is no out-of-pocket maximum for prescription drug coverage.

NOTE: Medications administered to you as an inpatient in a hospital, or injected in a physician's office, are covered under the medical portion of the plan, and are subject to the annual medical deductible and coinsurance. They are not part of this prescription drug portion of the plan.

Understanding Annual Medical Expenses Under POS C

Following are two examples showing the difference between the total annual POS C cost for covered medical expenses for "Joe" and for the plan in both a "normal" year for medical expenses and a "high-cost" year that includes significant medical expenses due to an inpatient hospitalization. In the "claim" column, it indicates whether the service is preventive care or medical care to help clarify why the portion paid by Joe is a copay (for preventive care) or coinsurance after deductible (for medical treatment). Please note, these examples do not include Joe's monthly contribution costs.



EXAMPLE 1: Joe has a "Normal" Year for Medical Expenses

Date	Claim	Cost of Service	Portion Paid by Joe	Portion Paid by POS C Plan	POS C Deductible Balance Remaining*	Out-of-Pocket Maximum Balance Remaining*
1/15	Annual physical at PCP (preventive care)	$ 100	$ 30 (copay)	$ 70	$ 300	$ 2,500
2/28	Allergist visit (medical treatment)	$ 100	$ 100 (toward deductible)	$ 0	$ 200	$ 2,400
4/28	Emergency room visit (medical treatment)	$ 1,000	$ 360 ($200 toward deductible, plus 20% of remaining $800)	$ 640 (80% coinsurance)	$ 0 (deductible now met)	$ 2,040
6/5	Sick visit to PCP (medical treatment)	$ 75	$ 15 (20% coinsurance)	$ 60 (80% coinsurance)	$ 0	$ 2,025
9/30	MRI test (medical treatment)	$ 1,500	$ 300 (20% coinsurance)	$ 1,200 (80% coinsurance)	$ 0	$ 1,725
TOTAL ANNUAL COST FOR MEDICAL EXPENSES		**$ 2,775**	**$ 805**	**$ 1,970**		**Out-of-pocket maximum not met**

**Amount declines as out-of-pocket expenses are incurred.*

Example 2 on next page

EXAMPLE 2: Joe has a "High-Cost" Year with a Hospital Admission

Date	Claim	Cost of Service	Portion Paid by Joe	Portion Paid by POS C Plan	POS C Deductible Balance Remaining*	Out-of-Pocket Maximum Balance Remaining*
1/15	Annual physical at PCP (preventive care)	$ 100	$ 30 (PCP copay)	$ 70	$300	$ 2,500
2/28	Allergist visit (medical treatment)	$ 100	$ 100 (toward deductible)	$ 0	$200	$ 2,400
4/28	Hospital admission for cardiac pain (medical treatment)	$20,000	$ 2,400**	$17,600 (80% coinsurance)	$ 0 (deductible now met)	$ 0 (out-of-pocket maximum now met)
5/15	Cardiologist office visit (medical treatment)	$ 125	$ 0	$ 125	$ 0	$ 0
6/15	Cardiologist office visit (medical treatment)	$ 125	$ 0	$ 125	$ 0	$ 0
7/15	Cardiologist office visit (medical treatment)	$ 125	$ 0	$ 125	$ 0	$ 0
9/30	MRI (medical treatment)	$ 1000	$ 0	$ 1000	$ 0	$ 0
10/20	Sick visit to PCP (medical treatment)	$ 100	$ 0	$ 100	$ 0	$ 0
11/17	Routine eye exam (preventive care)	$ 100	$ 35 (specialist copay)	$ 65	$ 0	$ 0
12/15	Cardiologist office visit (medical treatment)	$ 125	$ 0	$ 125	$ 0	$ 0
TOTAL ANNUAL COST FOR MEDICAL EXPENSES		**$21,900**	**$ 2,565*** **	**$19,335**		

**Amount declines as out-of-pocket expenses are paid by Joe.*
***$200 toward remaining deductible, plus $2,200 (20% coinsurance of remaining $19,800, capped by $2,500 out-of-pocket maximum).*
****Includes $2,500 out-of-pocket maximum plus $65 in copays for preventive services.*

UNDERSTANDING APPLICABLE MEDICAL EXPENSES UNDER POS C

As you consider the new POS C plan, it is important to understand what expenses do and do not apply toward the annual deductibles and out-of-pocket maximums. The following is a summary of expenses that ***do not*** count toward each of these features.

Feature	Expenses that DO NOT apply
Annual In-Network Medical Deductible	■ Preventive care services for which you pay a copay ■ Non-covered medical services ■ Services in excess of an annual plan limit ■ Out-of-network services ■ Prescription drugs covered under the prescription drug portion of the plan
Annual In-Network, Out-of-Pocket Maximum	■ Preventive care services for which you pay a copay ■ Non-covered medical services ■ Services in excess of an annual plan limit ■ Out-of-network services ■ Prescription drugs covered under the prescription drug portion of the plan
Annual Out-of-Network Medical Deductible	■ Preventive care services for which you pay a copay ■ Non-covered medical services ■ Services in excess of an annual plan limit ■ Amounts over the reasonable and customary (R&C) amount for the covered out-of-network expense ■ Prescription drugs covered under the prescription drug portion of the plan
Annual Out-of-Network, Out-of-Pocket Maximum	■ Preventive care services for which you pay a copay ■ Non-covered medical services ■ Services in excess of an annual plan limit ■ Amounts over the reasonable and customary (R&C) amount for the covered expense ■ Prescription drugs covered under the prescription drug portion of the plan
Annual Rx Deductible	■ Expenses other than covered prescription drugs ■ Prescription drugs that are covered under the medical portion of the plan, including drugs dispensed during an inpatient hospital stay, and those injected in a physician's office ■ Cost you pay for a greater than 30-day supply of prescription drugs purchased at a retail pharmacy

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2010 Prescription Drug News
for Pre-Medicare Retirees

CHANGE IN COVERAGE FOR DIABETIC MEDICATIONS AND SUPPLIES

Since RIT's pre-Medicare medical plans became self-insured in 2009, these plans are no longer required by New York State law to cover diabetic medications and supplies. As a result, beginning January 1, 2010, diabetic medications and supplies will now be covered under RIT's prescription drug coverage with Medco, rather than under the medical plans (POS A, POS B, POS B No Drug, and the new POS C).

As announced last fall, this change was delayed until 2010 to enable RIT to review the impact on our participants. As expected, as a result of this change, some people will pay less and some will pay more, but the impact is minimal on any one person. Only about 210 people are affected (out of about almost 3,000 employees and pre-Medicare retirees who have coverage). While some people will pay more for these items at the retail pharmacy, most of this increase is eliminated by using Medco By Mail, due to the discounted copays. For those who will pay more, the average cost increase is about $34 **per year**. On the other hand, some people will pay about the same, and some will even pay less!

This change is good for RIT and good for its medical plan participants because:

- Using one ID card simplifies your medication purchases.
- Medco has pharmacists specially trained to work with diabetics.
- You and RIT get the advantage of Medco's pricing and lower dispensing fees.
- You get the advantage of Medco's mail pharmacy.

For more details about getting started with Medco By Mail, and how you can save money, refer to the article, *Reminders About Medco By Mail*.

Getting Started with Medco By Mail is Simple

Contact your doctor for a new prescription so you can begin using the mail order program — request a prescription for a 90-day supply plus refills. Mail your prescription(s) to Medco or ask your doctor to use the prescription fax service. You can find the mail order form on the Medco website (**www.medco.com**) or by calling Medco toll-free at (800) 230-0508/V and (800) 759-1089/TTY). If your order is faxed, your doctor must have the member number from your Medco ID card.

Ordering refills is easy too, and you can receive reminder e-mails when it is time to refill a prescription. You can sign up for e-mail reminders and order online at **www.medco.com**. To order refills, you can also call 1-800-4REFILL (1-800-473-3455) and use the automated telephone system. If you order by phone or via Medco's website, you will need to provide your member number and the 12-digit prescription number found on the medication container and the refill slip.

Please note that whether you purchase your medication at the retail pharmacy or with Medco By Mail, ***you will pay the lower of the copay or the actual drug cost***.

REMINDERS ABOUT MEDCO BY MAIL

As you may know, you can save quite a lot of money on your maintenance prescriptions (those taken regularly for an ongoing medical condition, such as to lower blood pressure) by using Medco By Mail. If you (or a family member) use diabetic medications and supplies, remember that these items will be covered under the prescription drug plan and not the medical plan beginning January 1, 2010. To save money, you will want to start using Medco By Mail for these items (see article on page 10).

If the medication is a maintenance medication that can be filled in a 90-day supply with the mail order program, the "retail refill allowance" (RRA) will apply. Under RRA, on the 4th fill (original plus 3 refills) of a maintenance prescription purchased at a retail pharmacy, your copay for a 30-day supply will be equal to the copay for a 90-day supply of the medication, if you had ordered it from Medco By Mail. Copay comparisons are outlined in the charts at right and illustrate the significant cost savings when using Medco By Mail.

POS A and POS B

	RETAIL 30-day supply up to 3 fills	RETAIL 30-day supply after 3 fills	MEDCO BY MAIL 90-day supply
Tier 1: Generic Drugs	$ 10	$ 25	$ 25
Tier 2: Brand Name Formulary Drugs	$ 25	$ 62.50	$62.50
Tier 3: Brand Name Non-Formulary Drugs	$ 40	$100	$100

POS C

		Coverage Under POS C Once Annual Rx Deductible Has Been Met		
	Annual Deductible	RETAIL 30-day supply up to 3 fills	RETAIL 30-day supply after 3 fills	MEDCO BY MAIL 90-day supply
Tier 1: Generic Drugs	Each person must pay $250 annual deductible before copayment amounts are charged; drugs in all 3 tiers count toward this deductible.	$ 10	$ 25	$ 25
Tier 2: Brand Name Formulary Drugs		$ 50	$125	$125
Tier 3: Brand Name Non-Formulary Drugs		$100	$250	$250

NOTES: The RRA does not apply to acute care drugs such as antibiotics or medications that are not available from Medco By Mail, such as certain controlled substances — your copays for such medications purchased at a retail pharmacy will be the same as the copays for the first three fills.

SPECIAL NOTE FOR DIABETICS: Coverage for diabetic medications and supplies will begin January 1, 2010 under the prescription drug plan (see article to left). DO NOT use your Excellus BlueCross BlueShield ID card for diabetic medications and supplies — it will not work. Please remember to have enough supply on hand to get you through the first part of January since Medco By Mail cannot fill a diabetic-related prescription prior to January 1, 2010. The RRA would apply at the retail pharmacy on your fourth fill after January 1, 2010.

IMPROVED COVERAGE FOR COCHLEAR IMPLANTS UNDER POS A

We are pleased to announce an improvement to the POS A Plan for cochlear implant coverage effective January 1, 2010. With this improvement, a person in POS A can replace their processor every six years — even if it isn't broken or damaged. The Plan will pay 80%, up to $6,000 in total every six years.

Under insurance plans, replacement of a functioning processor is not typically covered. However, with technology improvements, speech understanding can be significantly improved with a newer processer. In RIT's unique position as a leader in educational development for the deaf and hard of hearing, it is important for us to serve as a model for other organizations. We took our first step when we introduced coverage for hearing aids many years ago. Now, we take another step with this improvement.

As a reminder, the POS A Plan covers hearing aids at 80%, up to $3,000 per ear every three years.

Choosing the Plan

That's Right for You

Because POS C has a different plan structure and plan features (e.g., deductibles, coinsurance, etc.) than our other POS options, it's important that you carefully consider which plan is right for you before making a choice. To help you do so, RIT Human Resources offers the following assistance to help you evaluate your options:

- Plan Overview at our retiree meetings (see schedule on page 3 of the retiree enrollment newsletter)
- Medical plan comparison tool on the HR website http://finweb.rit.edu/HumanResources/benefits/
- Examples of average medical expenses on the HR website
- New format for the Medical Benefit Comparison Book (enclosed with your enrollment mailing) to make it easier for you to locate the categories of expense that are important to you and your family members. Contact your benefits representative with any questions (refer to back of the retiree enrollment newsletter for contact information).

If you are moving from POS A or POS B to POS C, you will have significant savings in your monthly contributions. See the 2010 Medical Rate Summary Sheet enclosed with your enrollment mailing for specific comparisons of monthly contribution costs for each plan.

Because you may have higher out-of-pocket expenses throughout the year with POS C, than you did with POS A or POS B, we encourage you to set aside all or some of the savings from your lower monthly contributions to help pay for your medical and prescription drug expenses (while meeting your deductibles and out-of-pocket maximums). Even if you don't end up having to use these savings during the year, you will have the money available for a future year when your out-of-pocket expenses may be higher.