Your complete guide to the University’s Health Care Plans, Prescription Drug Plan, Dental Plans, FSA, HSA, Personal Health Management, and Well-U
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Promoting wellness and healthy living continues to be an important focus for the University of Rochester. To support our ongoing commitment, the University offers a benefits package designed to help faculty and staff and Strong Memorial Hospital residents and fellows make good health care decisions that not only help you live better, but also help you better manage health care costs.

The University of Rochester is committed to providing you and your family with a comprehensive and competitive benefits package. In order to meet this commitment and our business goals, we developed this Health Program Guide to highlight the benefits, programs, and services available to you.

Outlined in this Guide are the health program options available during the January 1 through December 31, 2018, Plan Year that include:
- Health Care
- Prescription Drugs
- Dental
- Vision
- Flexible Spending Accounts (FSAs)
- Health Savings Account (HSA)
- Biometric screening
- Personal Health Assessment (PHA)
- Condition management programs
- Lifestyle management programs
- Well-U
- Life-Work Connections/EAP
- Behavioral Health Partners

The health care choices you make—whether selecting health care coverage for you and your family for the coming year or deciding when and how to use health care services on a day-to-day basis—have a direct impact on the health care costs you and the University pay.

To help you maximize your health care offerings, the University offers lifestyle/condition management programs through YOURhealth and Well-U, which provide programs, tools, resources, and education necessary to support healthy living.

We encourage you to become involved with our health and wellness offerings, including taking your Personal Health Assessment (PHA) and completing a biometric screening. See pages 16–17 for more information.

Take the time to explore this Guide to learn more about the benefits and services that may help you change your behavior to become more involved in your health and use your benefits as wisely as possible.

### If you have questions about . . .

<table>
<thead>
<tr>
<th>Aetna</th>
<th>Excellus BlueCross BlueShield</th>
<th>Garnett-Powers &amp; Associates¹</th>
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<tbody>
<tr>
<td>Health Care Plans</td>
<td>1-877-864-4583</td>
<td>1-844-243-0027</td>
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<tr>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
<td><a href="http://www.garnett-powers.com/rochester">www.garnett-powers.com/rochester</a></td>
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<tr>
<td>Vision Benefit</td>
<td>1-877-864-4583</td>
<td>1-844-243-0027</td>
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<tr>
<td>Supplemental Vision Benefit</td>
<td>800-877-7195</td>
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<td></td>
<td><a href="http://www.VSP.com">www.VSP.com</a></td>
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<td>Accountable Health Partners</td>
<td>1-888-457-7463</td>
<td>N/A</td>
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<td></td>
<td>Direct: (585) 784-8855</td>
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<td></td>
<td><a href="http://www.ahpnetwork.com">www.ahpnetwork.com</a></td>
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<tr>
<td>Prescription Drug Plan</td>
<td>1-888-792-3862</td>
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<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<tr>
<td>Dental Plans</td>
<td>Excelus BlueCross BlueShield</td>
<td>1-844-243-0027</td>
</tr>
<tr>
<td></td>
<td>1-800-724-1675</td>
<td><a href="http://www.garnett-powers.com/rochester">www.garnett-powers.com/rochester</a></td>
</tr>
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</table>

### Put Your Health First

Take a more active role in your health. Eligible individuals can take the Personal Health Assessment (PHA) and enroll in a lifestyle/condition management program and earn incentives! For more information, see page 16 or contact the Center for Employee Wellness at (585) 275-6810.
<table>
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<tr>
<th>If you have questions about . . .</th>
<th>Contact Your Plan Administrator . . .</th>
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<tbody>
<tr>
<td>Flexible Spending Accounts (FSAs)</td>
<td><strong>Aetna</strong>&lt;br&gt;Aetna/PayFlex&lt;br&gt;1-888-678-8242&lt;br&gt;&lt;a href=&quot;www.aetna.com&quot;&gt;www.aetna.com&lt;/a&gt;, Aetna Navigator or directly at&lt;br&gt;&lt;a href=&quot;www.PayFlex.com&quot;&gt;www.PayFlex.com&lt;/a&gt;</td>
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<tr>
<td>Health Savings Account (HSA)</td>
<td><strong>Aetna</strong>&lt;br&gt;1-888-678-8242&lt;br&gt;&lt;a href=&quot;www.aetna.com&quot;&gt;www.aetna.com&lt;/a&gt;, Aetna Navigator or directly at&lt;br&gt;&lt;a href=&quot;www.PayFlex.com&quot;&gt;www.PayFlex.com&lt;/a&gt;</td>
</tr>
<tr>
<td>General Benefits</td>
<td><strong>UR Benefits Office</strong>&lt;br&gt;(585) 275-2084&lt;br&gt;Fax: (585) 273-1054&lt;br&gt;&lt;a href=&quot;benefitoffice@hr.rochester.edu&quot;&gt;<a href="mailto:benefitoffice@hr.rochester.edu">benefitoffice@hr.rochester.edu</a>&lt;/a&gt;&lt;br&gt;&lt;a href=&quot;www.rochester.edu/benefits&quot;&gt;www.rochester.edu/benefits&lt;/a&gt;</td>
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<tr>
<td>Updating your personal data or using HRMS to enroll online as a new hire</td>
<td>(585) ASK-URHR ((585) 275-8747)&lt;br&gt;&lt;a href=&quot;ask-urhr@rochester.edu&quot;&gt;<a href="mailto:ask-urhr@rochester.edu">ask-urhr@rochester.edu</a>&lt;/a&gt;&lt;br&gt;&lt;a href=&quot;www.rochester.edu/people&quot;&gt;www.rochester.edu/people&lt;/a&gt;</td>
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<td>Well-U Program</td>
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<td>• Condition Management Programs&lt;br&gt;• Biometric Screenings&lt;br&gt;• PHA</td>
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<tr>
<td>Lifestyle Management Programs</td>
<td>(585) 530-2050&lt;br&gt;&lt;a href=&quot;www.urwell.rochester.edu&quot;&gt;www.urwell.rochester.edu&lt;/a&gt;</td>
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<td>Behavioral Health Partners (BHP)</td>
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<td>Life-Work Connections/EAP</td>
<td>Life-Work Connections/EAP&lt;br&gt;(585) 475-0432&lt;br&gt;&lt;a href=&quot;www.urmc.rochester.edu/EAP&quot;&gt;www.urmc.rochester.edu/EAP&lt;/a&gt;&lt;br&gt;&lt;a href=&quot;strong_eap@urmc.rochester.edu&quot;&gt;<a href="mailto:strong_eap@urmc.rochester.edu">strong_eap@urmc.rochester.edu</a>&lt;/a&gt;</td>
</tr>
<tr>
<td>Long-Term Care (LTC) Insurance</td>
<td>For participants grandfathered and enrolled in the CNA group LTC plan:&lt;br&gt;CNA&lt;br&gt;1-877-430-5824&lt;br&gt;&lt;a href=&quot;www.cna.com/portal/site/groupLTC/&quot;&gt;www.cna.com/portal/site/groupLTC/&lt;/a&gt;</td>
</tr>
<tr>
<td>For participants with individual LTC policies through Legacy Services:&lt;br&gt;Legacy Services&lt;br&gt;1-800-230-3398, ext. 101&lt;br&gt;&lt;a href=&quot;custsvc@4groupltci.com&quot;&gt;<a href="mailto:custsvc@4groupltci.com">custsvc@4groupltci.com</a>&lt;/a&gt;&lt;br&gt;&lt;a href=&quot;http://main.legacyltci.com/&quot;&gt;<a href="http://main.legacyltci.com/">http://main.legacyltci.com/</a>&lt;/a&gt;</td>
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1. Garnett-Powers & Associates administers coverage for Postdocs only. All plans described in this chart are self-funded, and benefits are paid from the University’s general assets, with the exception of the Garnett-Powers options, which are insurer-funded and insurer-administered.
Official Plan Information

This Health Program Guide, along with the enrollment materials that you receive every year, are intended to constitute the Summary Plan Description (SPD) for the following plans:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan #</th>
<th>Plan Year</th>
<th>Type of Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Options</td>
<td>517</td>
<td>1/1 to 12/31</td>
<td>Group Health Plan providing medical benefits, vision benefits, Health Care FSA, Limited Purpose FSA, Prescription Drug benefits, Condition Management, Personal Health Assessment (PHA), Lifestyle Management, Behavioral Health Partners, biometric screenings, and flu shots</td>
</tr>
<tr>
<td>Dental Care Options</td>
<td>518</td>
<td>1/1 to 12/31</td>
<td>Group Health Plan providing dental benefits</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>515</td>
<td>1/1 to 12/31</td>
<td>Group Health Plan providing employee assistance plan benefits</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>519</td>
<td>1/1 to 12/31</td>
<td>Group Long-Term Care benefits</td>
</tr>
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</table>

1. Postdocs will receive Health and Vision coverage from Garnett-Powers & Associates; they are not eligible for a Flexible Spending Account or to receive services through Behavioral Health Partners. For Postdocs only, vision requires a separate election and is provided through a separate insurance policy.
2. Postdocs will receive Dental coverage through Garnett-Powers & Associates.
3. The details of the Long-Term Care plan coverage are not described in this booklet, but rather, in the separate certificate of coverage, which is hereby incorporated by reference. Please note that individual LTC policies purchased through Legacy Services are not part of Plan 519 or any other employee benefit plan sponsored by the University.

Your Guide to Making Enrollment Decisions

Health Care Plans, Prescription Drug Plan, Dental Plans, FSAs, and HSA

Choose and Use Benefits Wisely

You make choices each day that are unique to your work, family needs, and personal interests. Be sure to take time to carefully consider your benefit needs and options before making your elections. Consider the types of services and benefit features you need or want and the amount you can reasonably afford to pay out of pocket for the coverage.

Remember that your role as a responsible health care consumer does not end once you enroll for benefits. Throughout the year, you should take an active role in managing your health by maintaining a healthy lifestyle, choosing AHP or in-network providers when appropriate, evaluating your health care choices when care is needed, and using available resources wisely.

Your Options

You may have the opportunity to choose from the options outlined in the chart on the next page for your Health Program benefits.

Note: You may elect to waive your Health Care Plan coverage but still enroll in Dental Plan coverage, a Health Care FSA, and/or a Dependent Care FSA. If you elect to waive coverage for any benefit option, you must wait until the next Open Enrollment period or until you experience a qualifying event to enroll. See Appendix A for more information.

Available Coverage Levels

The coverage levels available to you for health care and VSP vision benefits are:

- Single
- Employee and Child(ren)
- Employee and Spouse or Domestic Partner
- Family

The coverage levels available to you for dental are:

- Single
- Family

Postdocs have the same four tier coverage levels for dental as they do for health care and vision.
Who Is Eligible for Benefits

Health Care Plans, Prescription Drug Plan, Dental Plans, FSAs, and HSA

<table>
<thead>
<tr>
<th>Benefits Available to You</th>
<th>Additional Information</th>
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<tbody>
<tr>
<td><strong>Health Care Options</strong></td>
<td></td>
</tr>
<tr>
<td>YOUR HSA-Eligible Plan</td>
<td>All full-time and part-time faculty and staff and Residents and Fellows are eligible for health coverage.¹ ² ³ ⁵</td>
</tr>
<tr>
<td>YOUR PPO Plan</td>
<td></td>
</tr>
<tr>
<td>Garnett-Powers &amp; Associates</td>
<td>Coverage through Garnett-Powers &amp; Associates is limited to Postdocs</td>
</tr>
<tr>
<td><strong>Dental Options</strong></td>
<td></td>
</tr>
<tr>
<td>Traditional Dental Assistance Plan</td>
<td>All full-time and part-time faculty and staff and Residents and Fellows are eligible for dental coverage.²</td>
</tr>
<tr>
<td>Medallion Dental Plan</td>
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<tr>
<td>Garnett-Powers &amp; Associates</td>
<td>Coverage through Garnett-Powers &amp; Associates is limited to Postdocs</td>
</tr>
<tr>
<td><strong>Vision Options</strong></td>
<td></td>
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<tr>
<td>VSP Supplemental Vision Benefits</td>
<td>All full-time and part-time faculty and staff and Residents and Fellows are eligible.² ¹</td>
</tr>
<tr>
<td>Garnett-Powers &amp; Associates</td>
<td>Coverage through Garnett-Powers &amp; Associates is limited to Postdocs</td>
</tr>
<tr>
<td><strong>Accounts to Help You Save on Taxes</strong></td>
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<tr>
<td>Health Care FSA</td>
<td>The Health Care FSA is not available if you elect to make contributions and/or receive UR funding to an HSA.</td>
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<tr>
<td>HSA</td>
<td>You can contribute only if you enroll in the YOUR HSA-Eligible Plan and are enrolled in an HSA.</td>
</tr>
<tr>
<td>Limited Purpose Health Care FSA</td>
<td>You can contribute only if you enroll in the YOUR HSA-Eligible Plan and are eligible to contribute to an HSA.</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>Dependent Care FSA is for day care expenses (not medical expenses) for your qualifying dependents (see page 47). You are eligible only if you have qualifying dependents.</td>
</tr>
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</table>

**Special Eligibility**

1199 SEIU members are not eligible to enroll in health or dental coverage; however, they may elect to contribute to a Health Care FSA.

Postdocs are eligible for health, dental, and vision coverage through Garnett-Powers & Associates. Postdocs are eligible for the Personal Health Assessment (PHA), Biometric Screening, Flu Shot, lifestyle management programs, condition management programs, and the Employee Assistance Plan (EAP) through the University.

Rochester as defined in the “Terms to Know” section of this Guide. Generally speaking, other employees, such as student employees, per diems, temporary employees, and any employee with a Time as Reported (TAR) appointment, are not eligible for health care options, unless they qualify as a full-time employee in accordance with the University’s Measurement and Stability Periods Policy.¹

Dependents eligible to be covered under your Health Care Plan, Dental Plan, and/or Vision Plan include:
- Your current spouse, if your marriage was valid in the state or country where it was performed
- Your domestic partner
- Your domestic partner’s children

¹ If you have a TAR appointment and are eligible for health care coverage through the University, your coverage will be effective per the guidelines in the University’s Measurement and Stability Periods policy.

Your children up through the end of the month in which they turn 26, regardless of access to other health care coverage through their own or a spouse’s employment, marital status, or student status

Your children who are handicapped prior to age 26 and are dependent on you for support

Your children include:
- Biological children
- Legally adopted children
- Stepchildren
- Children who are placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction

An employee’s domestic partner can have the same or opposite gender as the employee; the employee and his/her domestic partner must satisfy all of the following criteria:
• Have an exclusive mutual commitment, similar to that of marriage;
• Are each other’s sole domestic partner and intend to remain so indefinitely;
• Are not legally married to each other or to anyone else in a marriage recognized by state or federal law;
• Are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which the partners legally reside;
• Are at least 18 years of age and are legally competent to contract;
• Are currently residing together and have resided together in a common household for at least six consecutive months and intend to reside together indefinitely;
• At least six months have elapsed since the Benefits Office has received a Statement of Termination of Domestic Partnership from either partner; and
• Share joint responsibility for the partners’ common welfare and financial obligations demonstrated by: (a) the existence of a domestic partnership agreement (a qualifying domestic partnership agreement is a legally binding agreement between two individuals creating personal and financial interdependence, i.e., joint and several liability for each other’s debts and expenses, responsibility for mutual care, etc.); and (b) at least two other items showing joint responsibility, such as joint bank accounts, joint deed, mortgage agreement or lease, joint credit account or other liability, joint ownership of a motor vehicle, designation of domestic partner as primary beneficiary for life insurance or retirement contract(s), designation of domestic partner as primary beneficiary of will, durable property or health care power of attorney, co-parenting agreement, or an adoption agreement.

Important: Regulation for Domestic Partners and FSA/HSA Reimbursements
Your domestic partner (or their children) must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA or Health Care FSA. If you use HSA or Health Care FSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent, those funds are taxable, subject to a tax penalty, and must be reported on your federal tax return. The Plan may also seek to recover such funds. See Appendix B for more information on dependent eligibility for the FSA.

Dependent Eligibility
You may be contacted and required to provide documentation to confirm the members of your family who are eligible for benefits under a University Health Care Plan. This is to make sure that we are keeping track of dependents who may have reached the age maximum for Plan eligibility, spouses who are divorced and are no longer eligible, domestic partners and/or their children, or dependents who are deceased or otherwise ineligible for benefits. Please contact the UR Benefits Office if there is a change in eligibility status for any of your dependents covered under the Plan.

HSA and Medicare
If you enroll in the HSA-Eligible Plan and have Medicare coverage (Parts A, B, C, or D), you cannot contribute to an HSA.
If you are contributing to an HSA, please refer to pages 45–46 for important information.

Right of Rescission/Termination of Health Coverage
University of Rochester reserves the right to rescind coverage for an employee or family member if that person performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact with respect to the requirements for plan coverage. Rescission is a retroactive cancellation of coverage. Before rescinding coverage, the University of Rochester will provide 30 days’ advance written notice of the rescission. Coverage can also be terminated retroactively under certain circumstances permitted by the U.S. Depart-
ment of Labor, including non-payment of premiums or failure to report a dependent's loss of eligibility. These circumstances are not considered rescissions requiring 30 days' advance written notice.

**University Married Couples**

If you are married to a University faculty or staff member or SMH Resident or Fellow who also is eligible for University benefits, both you and your spouse may enroll for coverage. However, you and your dependents will not be allowed to be covered under two University health care plans or two Dental Plans at the same time.

**Retirees**

*Retirees of the University* are eligible for health care, dental and vision coverage.\(^2\) (A separate brochure explains the health care plans available to Medicare-eligible retirees, Medicare-eligible surviving spouses/domestic partners and eligible Medicare-eligible children.)

Your widow/widower and your eligible surviving dependents (see page 7) are eligible for coverage under a University Health Care Plan if at the time of your death:

- You had met the age and service requirements to retire, or
- You were retired, or
- You had five or more years of service but had not met the criteria to retire. (In this instance, your surviving spouse/domestic partner and eligible children remain eligible to continue coverage under a University Health Care Plan outlined in this Guide for a period of one year following your death. Following the one year of coverage through the University, they may be offered continuation coverage (COBRA) for up to 36 months.)\(^3\)

Health Care plan cost-sharing for surviving spouses/domestic partners and eligible children of active employees is determined by the Post-Retirement Grandparent Level that the employee would have had if he/she had retired. Surviving spouses/domestic partners and eligible children of active employees with a 4R and 5R Post-Retirement Grandparent Level pay the full premium for the plan.

Dental and VSP vision plan coverage ends upon the death of the active employee/retiree. Widows/widowers and eligible children will be offered 36 months of COBRA continuation coverage in the Dental and Vision Plans.\(^3\)

Individuals covered by collective bargaining agreements receive benefits in accordance with those agreements. Copies of those agreements are available upon written request.

**Retiree Eligibility and Cost of Coverage**

Regular employees who enter retirement status may be eligible for benefits in accordance with the terms outlined in the Post-Retirement Benefits Summaries. Retirees’ share of the premium costs vary depending on hire date, retirement date, age, and years of service of the retiree at the time of retirement. There is a separate Post-Retirement Benefits Summary for each Grandparent Level. The Benefits Office can provide you with the Post-Retirement Benefits Summary that applies to you based on your Post-Retirement Grandparent Level. The summaries also are available online at www.rochester.edu/benefits/post-retirement. The summaries will reflect your share of the premium for the coverages available to you. You will be billed quarterly by the University for your share, if any, of the premium cost for the coverage you have elected. Retirees must continue to pay their share of the premium for Health Care, Dental Plan and Vision Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month for which the premium has been paid in full, and notification of the coverage cancellation will be sent to the home address from the University.

Retirees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care or Dental Plan coverage until the next Open Enrollment period and until the premiums past due are paid to the University.

**Returning Retiree**

In the event a University of Rochester Retiree returns to work and becomes eligible for any health and welfare benefit option (i.e., medical, dental, etc.) because the Retiree has satisfied the eligibility criteria for active employees to participate, the Retiree will be limited to active employee benefit options and will become ineligible for post-retirement benefit options.

**Retirees and Covered Dependents**

**Becoming Eligible for Medicare**

If you continue to work full time or part time when you reach age 65, your University Health Care Plan remains the primary coverage, with Medicare as the secondary payer. When you retire, transfer to an ineligible status, or terminate your University employment, your primary coverage will become Medicare (Parts A and B).

Retirees and eligible dependents who are not eligible for Medicare coverage are eligible for the YOUR PPO Plan and/or the YOUR HSA-Eligible Plan until they become eligible for Medicare. When a retiree and/or eligible dependent becomes eligible for Medicare during retirement (or at retirement if already eligible for Medicare coverage at the time of retirement), coverage under these plans ends and the coverage is canceled. The Medicare-eligible individual(s) must complete an application for enrollment in one of the University of Rochester Medicare-Eligible Retiree plans if they wish to continue coverage through the University. Enrollment applications for GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO must be completed prior to the effective date of coverage. Enrollment applications for the University Complementary Care Plan with Major Medical must be completed within 30 days of the effective date of the coverage. Applications for enrollment are available from the Benefits Office. If you do not enroll in one of the University of

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\(^2\) The University reserves the right to change or terminate retiree health and dental coverage at any time, even for those who are already retired.

\(^3\) Please refer to pages 54-58 for additional information on COBRA continuation coverage for non-Medicare eligible individuals. For Medicare-eligible individuals, please see the COBRA continuation information in the Medicare-Eligible Retirees Health Program Guide.
Rochester Medicare-eligible retiree plans, you will not have coverage through the University.

Please note, since the Health Care Plans available to University of Rochester Medicare-eligible retirees (and their covered dependents) either supplement or coordinate with Medicare, retirees (and their covered dependents) must apply for original Medicare (Parts A and B) coverage prior to their 65th birthday. The Social Security Administration generally recommends that you contact Social Security three months before you turn age 65.

A separate brochure explains the Health Care Plans available to Medicare-eligible retirees, Medicare-eligible spouses/domestic partners, and eligible Medicare-eligible children. This brochure can be viewed at www.rochester.edu/working/hr/benefits/retirement/post-retirement/.

Special Note Regarding Taxation of Domestic Partner Coverage

Taxation If Your Domestic Partner Is Not Your Federal Tax Dependent

- For federal tax purposes, the premiums for domestic partners, and any children they bring to the partnership, are paid with after-tax dollars, while the premiums you pay for your own health care plan coverage are paid with tax-free dollars. You will also have imputed income equal to the value of the benefit provided by the University for these dependents. Only domestic partners and their children who do not qualify under IRS guidance as tax dependents are subject to this provision. See below for information on qualifying as a tax dependent for purposes of health plan coverage.

- Imputed income is the addition of the value of cash/non-cash compensation to an employee’s taxable wages in order to properly withhold income and employment taxes from the wages. The Internal Revenue Service considers the dollar value of medical and dental insurance coverage for domestic partners and their dependents as income for the purposes of calculating federal taxes. Affected employees must have this imputed income reported on their Form W-2. The taxable income includes the value of benefits paid by the University, in addition to the contribution that employees make.

Determined Whether Your Domestic Partner Is Your Federal Tax Dependent

You do not have to pay federal or state income tax on the value of benefits for your domestic partner if he or she is a tax dependent that meets the requirements under Section 152 of the Internal Revenue Code (as modified by Code §105(b) and by IRS Notice 2004-79). Although you must consult with a tax advisor to determine if your domestic partner is a tax dependent, the general requirements are:

- Your domestic partner must have had the same principal residence as you for the entire calendar year;
- Your domestic partner must be a member of your household for the entire calendar year (and the relationship must not violate local law);
- During the calendar year, you must provide more than half of the total support for your domestic partner;
- Your domestic partner must not be claimed as a child on anyone else’s tax return; and
- Your domestic partner must be a United States citizen; a U.S. national; or a resident of the United States, Canada, or Mexico.

To determine whether you provide more than half of the total support for your domestic partner, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including Social Security, welfare payments, the support you provide, and the support your domestic partner provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of the support for your domestic partner, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information). Please note, an individual could qualify as a tax dependent for health insurance purposes, but not on your tax return, if they earn more than $4,050 (the exemption amount as defined in Code §151(d) for 2017), but still receive more than half of their support from you.

The same test applies to determine whether coverage for your domestic partner’s children is subject to federal income taxation. Consult with your tax advisor to determine whether your domestic partner or their children are your tax dependents for purposes of health plan benefits. If you believe they are, then you should contact the Benefits Office and ask to complete a tax dependent affidavit.

4 To determine whether you provide more than half of the total support for your domestic partner, you must consult with a tax advisor to determine whether your domestic partner or their children are your tax dependents for purposes of health plan benefits. If you believe they are, then you should contact the Benefits Office and ask to complete a tax dependent affidavit.
Enrolling for benefits is easy. The following checklist takes you through the steps you need to complete to elect your Health Program options for 2018.

1. **Review this Guide.**
   Carefully read this Guide to understand all of the Health Program option(s) available to you and your dependents.

2. **Review the Health Plans Comparison Chart.**
   The chart compares the YOUR PPO Plan and the YOUR HSA-Eligible Plan. It also shows how services are covered under each of the Plans.

3. **Learn about the Plans.**
   Read the TPAs benefit booklets to understand how the Plans work. Read the Summaries of Benefits and Coverage for additional information.

4. **Utilize the Online Benefits Decision Tool.**
   ALEX is an online benefits decision tool that will help you understand the various benefit options and empower you to make informed decisions when it comes to making your benefit elections.

5. **Health Care Plan Coverage Comparison Scenarios.**
   The scenarios posted on the Benefits website (www.rochester.edu/benefits) compare how different sets of services might be covered under the University's two Health Care Plans based on the defined assumptions for each scenario. Each scenario details a comparison of annual payroll contributions for health care premiums, estimated costs of care for services, estimated total annual cost, and the potential savings associated with each Plan.

6. **Choose a TPA.**
   If you enroll for health care coverage, you will need to select a Third-Party Administrator (TPA). (If you elect to contribute to an FSA but waive your health care plan coverage, Lifetime Benefits Solutions, Inc. will be the administrator of your FSA.) Turn to pages 31–32 for information about the two TPAs.

7. **Enroll for Benefits.**
   If you are a new hire and are enrolling for the first time, you can enroll for benefits online using HRMS within 30 days of your hire date. To enroll online, log on to HRMS at www.rochester.edu/people. Select Self-Service, then Benefits, and then Benefits Enrollment.
   
   **If you do not wish to enroll online:**
   - Download the enrollment form at www.rochester.edu/benefits/health (go to Forms), or
   - Contact the UR Benefits Office for the enrollment form by:
     - Calling (585) 275-2084,
     - Emailing benefitoffice@hr.rochester.edu, or
     - Visiting the UR Benefits Office.
   - Submit a completed enrollment form to: University of Rochester Benefits Office 44 Celebration Dr., Suite 2300 PO Box 270453 Rochester, NY 14627

   **Residents and Fellows**
   **Medical, Dental, and Vision Coverage:** for new hires, participation begins on the first day of employment, so long as the enrollment forms are completed and submitted within 30 days of the Employee's hire date. Though coverage may begin in the middle of the pay period, the premium deduction will not be prorated; see the Residents and Fellows Premium Rate sheet on the Benefits website to view the deduction amounts. For Employees becoming eligible for benefits under the Plan due to a change in status (e.g., those changing from an ineligible to an eligible status, or those being hired by the University who have worked for an Affiliate within the last 30 days), coverage will be effective on the date of the appointment, or the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), whichever is later.

   **Health Care Flexible Spending Account and Dependent Care Flexible Spending Account:** participation begins the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), or the date of hire, appointment, or change to eligible status, whichever is later.

   **Health Savings Account:** participation begins the first day of the pay period following the date the account is established, the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), or the first day of the calendar month following or coincident with the effective date of YOUR HSA-Eligible Plan Coverage, whichever is later.

   **Faculty and Staff**
   **Medical, Dental, and Vision Coverage:** for new hires, participation begins the first day of the month following or coincident with the hire date. For Employees becoming eligible for benefits under the Plan due to a change in status (e.g., those changing from an ineligible to an eligible status, or those being hired by the University who have worked for an Affiliate within the last 30 days), coverage will be effective the first of the month following or coincident with the date of the appointment, or the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), whichever is later.
Health Care Flexible Spending Account and Dependent Care Flexible Spending Account: participation begins the first day of the month following or coincident with the date of the hire, appointment, or change to eligible status, or the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), whichever is later.

Health Savings Account: participation begins the first day of the pay period following the date the account is established, the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), the date of the appointment or change to eligible status, or the first day of the calendar month following or coincident with the effective date of YOUR HSA-Eligible Plan Coverage, whichever is later.

Changing Your Benefits

Health Care Plans, Prescription Drug Plan, Dental Plans, FSAs, and HSA

Can I Enroll at Another Time?
Annual Open Enrollment is the primary time you can enroll or make changes to your Health Care Plan options and FSA contributions. Outside of Open Enrollment, you can only enroll in or change your Health Care Plan options, Dental Plan options, Vision Plan options, and FSA contributions or add/remove eligible dependents to/from your Health Care Plan and/or Dental Plan, if you have a qualifying event or a HIPAA special enrollment period.

Qualifying Event Enrollment Period Changes
Additional qualifying events are provided in Appendix A, but common qualifying events include:

- Change in legal marital status (marriage, divorce, death of spouse, or annulment)
- Change in number of dependents (birth, adoption, placement for adoption, or death)
- Change in your employment status (that affects your benefit eligibility) or that of your spouse or dependent
- Dependent satisfying (or ceasing to satisfy) eligibility requirements for coverage (reaching the age at which coverage is no longer available, etc.)
- Change in cost of day care coverage, such as a significant increase charged by your current day care provider or a change in your provider (this applies to the Dependent Care FSA only).

Any changes you make must be “due to and consistent with” your qualifying event. The Plan Administrator will determine whether a requested change is due to and consistent with a qualified change in status.

The consistency requirements vary depending on the type of qualifying event. To satisfy the “consistency rule” for certain qualifying events, including those events listed above, your qualified change in status and corresponding change in coverage also must meet both of the following requirements:

- **Effect on eligibility.** Except for the Dependent Care FSA, the qualified change in status must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage, or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan. For the Dependent Care FSA, the qualified change in status must affect the amount of dependent care expenses eligible for reimbursement. For example, if your child reaches age 13, his or her dependent care expenses are no longer eligible for reimbursement.

- **Corresponding election change.** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the University Health Care Plan, you may cancel Health Care Plan coverage only for the dependent that lost eligibility. Additionally, you may change or begin contributions to your Health Care or Dependent Care FSA if you have or adopt a child, or a child is placed with you for adoption.

Questions

- Call (585) ASK-URHR (585) 275-8747 if you have questions about enrolling through HRMS.
- Call the UR Benefits Office at (585) 275-2084 if you have questions about your benefit plans.

Enrollment Form

Your enrollment form must be received by the Benefits Office within 30 days of when you become benefits-eligible. Enrollment forms received after 30 days may result in no coverage until the next Open Enrollment or until you experience a qualifying event. (Please refer to Appendix A for when you can make benefit changes outside of Open Enrollment.)

How to Change Your Coverage

If you need to change your coverage because of a qualifying event, you will need to complete an Qualifying Event Change form and return the completed form to the UR Benefits Office within 30 days of the qualifying event (or within 60 days for Medicaid or CHIP eligibility events). Coverage will generally be effective on the date of the event or the date the completed form is received in the Benefits Office, whichever is later. Medical coverage changes due to birth adoption or placement for adoption will be effective on the date of the event. If you are currently covering a domestic partner and get married, within 30 days of the date of the marriage you must submit the Personal Data Change Form and the Qualifying Event Form to update your spouse’s relationship designation and avoid taxation issues related to health and/or dental premium deductions. See Appendix A for more information regarding permitted election changes and when they are effective.
Note: When changing due to a qualifying event, your FSA annual election cannot be reduced below the amount of payroll contributions already deducted or claims already submitted for the calendar year if it would result in a negative balance and the change must be consistent with the qualifying event.

Depending on the circumstances, you may also be able to make changes throughout the year for the following reasons:
- Court judgment, decree, or order to provide coverage to a dependent
- COBRA events
- An eligible dependent drops his or her coverage from another employer’s plan during an open enrollment period which is different than that of the University’s
- Commencement or return from FMLA leave
- Loss of Medicaid entitlement by you, your spouse, or dependent

As noted, additional qualifying events are provided in Appendix A, but you should contact the Benefits Office if you have any questions regarding qualifying events.

HIPAA Special Enrollment Period Changes
If you are declining enrollment in the plan 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 this plan if:
- you or your dependents lose eligibility for that other coverage, or
- an employer stops contributing toward the cost of your or your dependents’ other coverage; or
- you or your eligible dependents exhaust COBRA coverage.

However, you must request enrollment within 30 days after your or your dependents’ other coverage or COBRA ends (or after the employer stops contributing toward the other coverage).

In addition, you can request (within 30 days) to enroll in the plan or enroll your eligible dependents if:
- you marry, or
- you gain a new dependent because of birth, adoption or placement for adoption.

You can also request (within 60 days) to enroll in the plan or enroll your eligible dependents if you or your eligible dependent:
- loses Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- become eligible for a state’s premium assistance program under Medicaid or CHIP.

To request special enrollment or obtain more information, contact the Benefits Office at (585) 275-2084 or email benefitoffice@hr.rochester.edu.

When Coverage Ends
Except as noted elsewhere in this booklet, your participation in the plan(s) will end upon occurrence of the earliest of the following events:
- You or your dependents no longer meet the eligibility requirements;
- You fail to make required contributions;
- You drop coverage for yourself or your dependents;
- Your or your dependents’ benefits are terminated due to fraud or intentional misrepresentation against the plan(s);
- You terminate employment with the University;
- You retire but are ineligible for retiree benefits under the plan(s) described in this booklet, due to Medicare eligibility or otherwise;
- You die (except as noted for surviving spouses and dependents on page 9);
- The University terminates the plan(s) in which you are participating;
- Coverage under the insurance contract funding the plan(s) terminates, or the insurer ceases providing benefits due to bankruptcy.

In some cases, coverage extends until the last day of the pay period or calendar month in which the event occurs. For example, children turning age 26 will have coverage extended until the last day of the month in which their 26th birthday falls.

Failure to Enroll
If you do not enroll during the initial enrollment period, your Health Program coverage will be defaulted to:
- Waived (No coverage) for Health Care Plan
- Waived (No coverage) for Dental Plan
- Waived (No contributions) for Health Care and Dependent Care FSA

If you do not make coverage changes during the annual open enrollment period:
- Medical, Dental, and Vision Plan elections will continue
- Enrollment in a Tax-Advantaged Account will discontinue as of the first of the year

Limitations
- If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions to your HSA via payroll deduction will stop on the effective date (see “If you terminate or change to an ineligible status,” on page 62).

- If you enroll for coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, you may be eligible to contribute to a Limited Purpose Health Care FSA and an HSA; however, the HSA contribution maximums (see page 45) are prorated if you will be covered by the YOUR HSA-Eligible Plan for less than 12 months within the calendar year.

- If you are already enrolled in the Health Care FSA, you cannot enroll in a Limited Purpose FSA and HSA until the next Open Enrollment.
When it comes to the health and wellness of our employees and their families, we offer a wide array of programs and services to help you prevent or manage health issues affecting your life. Becoming healthier not only reduces risk for disease and helps us live longer, it also helps us live better.

The University is committed to promoting a culture of wellness. We offer opportunities for you to improve your health, ranging from on-site biometric screenings, a Personal Health Assessment (PHA), lifestyle and condition management programs, indoor walking routes, a program to reward healthy eating, and more choices for faculty and staff to lead happier, healthier lives.

Make a commitment to yourself and your family to become healthier. You can become a Well-U champion and promote wellness within your department. The University also encourages you to participate in ongoing awareness campaigns and events throughout the year, including Go Red Day, American Heart Walk, and Making Strides Against Breast Cancer Walk.

It is up to you to take the steps to better health, but you do not have to do it alone. The University provides the support, tools, and resources to help you achieve your health goals.

### Steps to Take Charge of Your Health

1. Complete your biometric screening and PHA questionnaire
2. Enroll in a lifestyle management program
3. Enroll in a condition management program (if eligible)
4. Participate in Well-U Programs and events
5. Utilize Life-Work Connections/EAP and Behavioral Health Partners
6. Review your Health Care Plan and Prescription drug options
7. Get an annual flu shot

See pages 16–19 for more information.

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**Learn about the University’s Wellness Programs**

Check out the University’s employee wellness initiative, Well-U.

**Participate in Well-U Programs**

Through Well-U, you may have the opportunity to participate in valuable on-site programs, including:

- Wellness challenges
- Flu shots
- Guided relaxations
- Lunch and learns
- Live cooking demos
- Pet therapy events
- Stress management workshops
- Weight Watchers
- Fitness classes
- Self-defense classes
- Good Food Collective
- On-site farmers market

These programs are available at numerous locations throughout the University and at off-site locations, making it convenient for you to participate.

**The Well-U Mission**

Well-U, our award-winning wellness program, can help improve the health and wellness of University faculty and staff and SMH residents and fellows by promoting a work environment that encourages healthy behaviors and by providing the tools, resources, and education necessary to support healthy living.

For more information, go to [www.rochester.edu/well-u](http://www.rochester.edu/well-u), call (585) 273-5240, or email well-u-info@rochester.edu.
# 2018 Eligibility Table

The University of Rochester offers health and wellness programs for employees. This document provides a brief overview of those programs and their corresponding eligibility. For more information, visit [www.rochester.edu/well-u](http://www.rochester.edu/well-u).

<table>
<thead>
<tr>
<th>Programs</th>
<th>Faculty, staff, residents, and spouses/domestic partners enrolled in a University Health Care Plan¹</th>
<th>Regular full-time/part-time faculty and staff (including SEIU members) not enrolled in a University Health Care Plan</th>
<th>Postdocs and spouses/domestic partners enrolled in a University-sponsored health care plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biometric Screenings and Personal Health Assessment (PHA)</td>
<td>Eligible (plus incentive)</td>
<td>-</td>
<td>Eligible (plus incentive)</td>
</tr>
<tr>
<td>Lifestyle Management Programs</td>
<td>Eligible (plus incentive)</td>
<td>-</td>
<td>Eligible (plus incentive)</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)²</td>
<td>Eligible</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Well-U Programs³</td>
<td></td>
<td></td>
<td>Eligible</td>
</tr>
<tr>
<td>- Fitness classes, live cooking demos, on-site farmers market, self defense classes, and more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Watchers (at work and online)³</td>
<td>Eligible (plus incentive)</td>
<td>Eligible (plus incentive)</td>
<td>Eligible (plus incentive)</td>
</tr>
<tr>
<td>Condition Management Programs</td>
<td>Eligible (plus incentive)</td>
<td>-</td>
<td>Eligible (plus incentive)</td>
</tr>
<tr>
<td>Condition Management Rx/Dx Discount</td>
<td>Eligible</td>
<td>-</td>
<td>Eligible</td>
</tr>
<tr>
<td>Nurse Lines</td>
<td>Eligible</td>
<td>-</td>
<td>Eligible</td>
</tr>
<tr>
<td>Flu Shots</td>
<td>Eligible</td>
<td>-</td>
<td>Eligible</td>
</tr>
<tr>
<td>Behavioral Health Partners (BHP)⁴</td>
<td>Eligible</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

¹. Including non-Medicare eligible retirees and spouses/domestic partners enrolled in a University health care plan.

². Eligibility for the Employee Assistance Program includes all employees and their immediate family members.

³. Eligibility for Well-U Programs and Weight Watchers (at work and online) includes all regular full-time, part-time faculty, staff, residents, and postdocs.

⁴. Eligibility for Behavioral Health Partners (BHP) includes regular full-time and part-time faculty and staff age 18 or older and non-Medicare-eligible retirees enrolled in a University Health Care Plan as well as spouses/domestic partners and dependent children of active employees or non-Medicare-eligible retirees who are 18 or older and enrolled in a University Health Care Plan.

- The EAP for Faculty and Staff of the University of Rochester includes only the Strong EAP. Biometric screenings, lifestyle management programs, Personal Health Assessment, BHP, condition management programs, flu shots, and the 24/7 Nurse Lines are part of the University health care plans.
- This document provides only a summary of some of the features of these plans. Detailed information on the plans is available on the Benefits website ([www.rochester.edu/benefits](http://www.rochester.edu/benefits)), or a paper copy of the information is available for free from the Benefits Office.
- The University reserves the right to modify, amend, or terminate the plans or programs at any time, including actions that may affect coverage, cost-sharing or covered benefits, as well as benefits that are provided to current and future retirees.
Coverage for Preventive Services

Certain preventive services received from in-network providers will be eligible for coverage at 100% by your University Health Care Plan. Your Plan covers in-network preventive services that have in effect a rate of A or B as outlined in the National Guidelines for Preventive Care Services established by the U.S. Preventive Services Task Force (an independent panel of experts in primary care and prevention that reviews the evidence of covered preventive services), subject to the clinical policies established by the Third-Party Administrator (TPA) who administers your University Health Care Plan. It also covers immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; preventive care and screening for infants, children, and adolescents provided for in guidelines by the Health Resources and Services Administration (HRSA); and preventive care and screenings for women provided for in guidelines by the HRSA. The plan’s covered preventive services are updated each plan year to incorporate any new guidelines that have been in effect for more than 12 months.

The University believes that maintaining good overall health should not be a financial burden. Studies show that routine checkups and screenings are the most effective ways to detect and prevent serious medical conditions. Early detection is linked to higher recovery rates and less invasive and less costly medical treatment, which includes routine screenings and regular checkups, routine gynecological visits and well-child exams.

Note: Preventive services do not include regular visits to your doctor to diagnose or treat a problem, disease, or injury that you have, nor are the services intended for regular testing or monitoring for a condition, such as high cholesterol, high blood pressure, or diabetes. In these cases, copays, coinsurance, and deductibles apply. To ensure 100% coverage, you should confirm that your doctor is an in-network provider, the service you are seeking is preventive, as determined by your TPA’s medical management guidelines, and that your doctor will bill your TPA appropriately. All care is subject to meeting the clinical policies established by the TPA that administers your University Health Care Plan.

The University has been providing preventive services based on USPSTF recommended guidelines since 2008. Due to Health Care Reform legislation, which affords each TPA discretion to administer preventive services based on the TPAs’ interpretation of the recommended guidelines, please call or visit your TPA’s website (Aetna or Excellus BlueCross BlueShield) for additional information regarding new, important screenings and for a copy of your TPAs Preventive Services Guide:

- **Excellus BlueCross BlueShield**: [https://www.excellusbcbs.com/ur](https://www.excellusbcbs.com/ur)

Additionally, you may be contacted by your TPA if you qualify for additional Condition Management outreach that can help improve your health. You may receive postcard reminders, educational materials, and/or automated phone calls and emails to help you improve the use of preventive health services and management of acute and chronic conditions.

Know Your Numbers: Get a Free Biometric Screening and Take the Personal Health Assessment

Well-U sponsors biometric screenings for eligible participants. Regular full-time and part-time faculty and staff, non-Medicare-eligible retirees, spouses, and domestic partners enrolled in a University health care plan and Postdocs, spouses, and domestic partners enrolled in a University-sponsored health care plan will be required to show their University ID card to receive a screening; however, there is no cost to participate.

Screening appointments can be scheduled by using the online scheduling system at [https://schedule.son.rochester.edu](https://schedule.son.rochester.edu). Walk-ins are accepted, but it is better to schedule an appointment to ensure that you will be seen on the day/time of your choice.

A biometric screening takes approximately 15 minutes and includes the following measures:

- Blood pressure and heart rate
- Height, weight, abdominal girth, and body mass index
- Total cholesterol, HDL, and triglycerides
- Glucose

The results are available immediately, and your nurse will talk to you about what the numbers mean. You will receive brief health coaching, educational materials, and information about referrals to programs. In cases where your biometric screening shows out-of-range biometric numbers, the nurse
will provide more in-depth counseling. You will leave with a report that has your results recorded on it.

You can complete your Personal Health Assessment online at https://urwell.rochester.edu. The PHA is an easy, online tool that helps you gauge your current level of health and wellness through a series of questions about your lifestyle. Your biometric values will be entered into your PHA automatically by the nurse who completed the screening. Upon completion, you will receive a comprehensive, personalized, and confidential report that offers suggestions and available resources to achieve a healthier lifestyle. You will also have access to available resources and educational content personalized to fit your needs. Your PHA will tell you what areas of your health you may need to improve upon and provide you with tips, recommendations, educational materials, and if applicable, referrals to wellness programs that may benefit you. Share the PHA summary report with your primary care provider at your next visit and talk with him or her about your results and recommendations.

Lifestyle Management Programs

Lifestyle management programs are offered in-person, one-on-one, or in small group sessions.

See the YOURhealth Program Catalog for additional information regarding available programs.

Please note: The Healthy Living Center will work with you to help determine the program that best fits your needs. For more information, visit www.rochester.edu/well-u or call the Healthy Living Center at (585) 530-2050.

Completing Your Personal Health Assessment

To help encourage you to make an important investment in your health, the University offers a $125 incentive if you complete both your biometric screening and PHA. You and your spouse or domestic partner (if enrolled in a University Health Care Plan) may each receive this incentive. If you choose to obtain your biometric numbers through your doctor’s office, you should download the Health Screening Form that can be completed and signed by your doctor’s office from https://urwell.rochester.edu and click on Biometric Screening.

A completed Health Screening Form or biometric screening must be submitted by December 31, 2018, in order to qualify for the 2018 incentive.

Note: The monetary incentive is considered taxable and will be subject to normal wage withholding. Faculty and staff and SMH residents and fellows, as well as spouses and domestic partners, are eligible for the incentive only once during the Plan Year that runs from January 1 to December 31. SEIU members are no longer eligible to take the PHA or have a biometric screening.

1 The information you share in the PHA and the results of your biometric screenings are kept confidential and are protected by several laws, including HIPAA and the Americans with Disabilities Act, as well as the University's internal policies. The information will be used only to promote your health and may be forwarded to your personal physician or to other University health plans for purposes of treatment, payment, and health care operations. Specifically, the University of Rochester Health Care Plans (including Lifestyle Management, Condition Management and Behavioral Health Partners) and the Employee Assistance Program are part of an Organized Healthcare Arrangement, which means that protected health information can be shared among those plan components for purposes of treatment, payment, and health care operations without the need for your consent or authorization to use or disclose your health information to carry out those functions. Only University employees and vendors responsible for administering those plans, such as employees who work in the Benefits Office, the School of Nursing, the Healthy Living Center, and Behavioral Health Partners, who perform services for the plan, have access to protected health information. Those employees are trained on privacy procedures and are subject to disciplinary action for failure to comply. The types of information obtained in the Personal Health Assessment (PHA) include demographics and employment information, lifestyle habits, and personal medical history. See the YOURhealth Program Catalog for more information on how your health information is shared and protected.

Condition Management Programs

If you need some guidance to help manage a chronic condition, the University offers condition management coaching programs designed to give you the tools and resources you need to better reduce symptoms related to your condition. These programs give you the tools and information you need to better reduce symptoms related to chronic conditions. You will meet one-on-one with a registered nurse wellness coach and a fitness specialist and nutritionist, as needed, to learn how to make appropriate lifestyle changes to help reduce symptoms related to chronic conditions. You may receive a call from a nurse or representative if you qualify for the program. Or feel free to call (585) 275-6300 if you would like to learn more.

See the YOURhealth Program Catalog for additional information regarding available programs.

Condition Management Prescription Drug Copay Discount Program

Eligible participants enrolled in a University Health Care Plan who are managing one of the following chronic conditions through the condition management program, may qualify for reduced copays for their medications while actively participating in the program: including asthma, CAD, CHF, diabetes, or high blood pressure.

The Condition Management Prescription Drug Copay Discount Program provides participants with a discount off their eligible prescription drug copay or a discount off their coinsurance for eligible diabetic supplies and equipment to treat these conditions or co-morbid conditions under the respective University health care plans.

• The Condition Management Prescription Drug Copay Discount Program applies to eligible drugs only for the five programs listed above. It does not apply to those Program participants managing AFIB, COPD, high cholesterol, low back pain, or stroke.
• Participants under the YOUR HSA-Eligible Plan are not eligible for the condition management program discount until after meeting the deductible and before reaching their out-of-pocket maximum.

Participate in Case Management
You may be recommended for case management if you need additional assistance above and beyond a condition management program. Based on your health claims data, your TPA may recommend that you participate in a case management program to help manage a health condition you may have. The University strongly encourages you to enroll and complete the program.

Incentives for Lifestyle/Condition Management Programs
You may qualify for a $100 cash incentive if you successfully complete a lifestyle/condition management program. This means you can earn up to $200 ($100 for a lifestyle management program and $100 for a condition management program, if you are eligible). To be eligible, you must be a regular full-time or part-time faculty member, staff, SMH Resident, Fellow, non-Medicare-eligible retiree, spouse, or domestic partner enrolled in a University health care plan or a Postdoc, spouse, or domestic partner enrolled in a University-sponsored health care plan. Spouses and domestic partners of active employees as well as spouses and domestic partners of non-Medicare eligible retirees who are enrolled in a University Health Care Plan also qualify for the incentive.

Note:
• SEIU members are not eligible to participate in the condition management program or in the lifestyle management program.
• The cash incentive is considered taxable and will be subject to normal wage withholding.
• Eligible participants may receive the incentive only once for a lifestyle management program and once for a condition management program during the Plan Year that runs from January 1 to December 31.

Follow-up Biometric Screenings
Upon completing either a lifestyle or condition management program for cholesterol or a condition management program for diabetes, you can receive a follow-up screening to check your cholesterol or glucose numbers. Upon completion of one of the programs listed above, your health coach will give you more information about when you should have your follow-up numbers screened. You can then compare your “new” numbers with where you started to measure your success and progress. Even if you don’t participate in a program, but want to double check your cholesterol or glucose numbers, and you have had a biometric screening done during the calendar year, you can sign up for repeat cholesterol or glucose number follow-ups by visiting https://schedule.son.rochester.edu/roc.

You will receive your results immediately, along with educational materials and the opportunity for brief health counseling. If appropriate you may receive a referral for lifestyle management programs or for condition management programs. Your biometric values will be automatically entered into your PHA by the nurse who completed the screening.

Need Assistance with a Health Care Decision? Talk to a Nurse Advocate
When you have a health question and you’re not sure what to do, you can call the Nurse Line 24 hours a day; seven days a week. The Nurse Line provides direct access to registered, specially trained nurses who can help answer your questions, discuss your options, and empower you to make informed decisions. A nurse can also help prepare you for your next doctor’s office visit by providing you with meaningful questions to discuss with your doctor. You can also call the Nurse Line for general health information; wellness and prevention education; tips and advice on nutrition, exercise, and weight loss; and chronic condition support. If you are enrolled in a University Health Care Plan, please see the TPA numbers below:
• Excellus BlueCross BlueShield members, please call 1-800-348-9786.
• Aetna members, please call 1-800-356-1555.

Eligibility
Those eligible for the biometric screenings, the PHA, lifestyle management programs, and condition management program and incentives include:

• Regular full-time and part-time faculty, SMH residents and fellows, and staff and spouses or domestic partners enrolled in a University Health Care Plan
• Non-Medicare-eligible retirees and spouses or domestic partners enrolled in a University Health Care Plan
• Postdocs and spouses or domestic partners enrolled in a University-sponsored health care plan

Please note: SEIU members who are not enrolled in a University Health Care Plan are not eligible. For additional eligibility information, please visit the Well-U website at www.rochester.edu/well-u.

Use the Employee Assistance Program (Life-Work Connections/EAP)
Life-Work Connections/EAP offers free assessment, short-term counseling, and referral information to employees and their family

Your Privacy Is Protected
The personal health information you supply is completely confidential, protected by federal law and cannot be divulged to anyone without permission except as described in the Plans’ Notice of Privacy Practices and the disclosure notice contained in the YOURHealth Catalog. The PHA, biometric screenings, and condition management programs are administered by the University of Rochester School of Nursing Center for Employee Wellness. Lifestyle management programs are administered by the URMC Healthy Living Center. The information from your PHA will be shared with the URMC Healthy Living Center and the UR School of Nursing Center for Employee Wellness in order to determine if you qualify to participate in the program. The University will only be provided with aggregate data for the University population as a whole, for the sole purpose of performing program analysis.
members. You can speak confidentially with experienced counselors who will help you understand your options. The goal is to address these issues before job performance is affected. Finding solutions to problems or developing better coping techniques will help you to better manage life’s difficulties. Life-Work Connections/EAP services are free of charge.

In general, all employees and their immediate family members are eligible to use Life-Work Connections/EAP services. Often, when one family member is experiencing some difficulties, it affects other family members as well. Therefore, you and your immediate family members or any member of your household are also eligible to use the service. Each eligible family member is allowed up to five Life-Work Connections/EAP counseling sessions per year. You may verify eligibility by contacting our office directly at (585) 475-0432.

Life-Work Connections/EAP’s providers have master’s degrees/licenses in either Mental Health Counseling or Social Work. Some staff are also Certified Employee Assistance Professionals.

Although you may call for any type of concern or problem, there are some issues that are handled more frequently through the Life-Work Connections/EAP. The most common problems include:

- Problems with a supervisor or co-worker
- Depression or anxiety
- Grief and bereavement
- Family, marriage, and other relationship issues
- Domestic violence
- Addictions (drug, alcohol, sexual, gambling, shopping, internet, etc.)
- Eating disorders
- Child and adolescent issues
- Child-parent problems
- Stress-related illness
- Coping with chronic illness
- Financial problems

The Life-Work Connections/EAP provides counseling for a variety of issues that can be handled within a brief time frame. While some issues brought to the Life-Work Connections/EAP can be addressed within a few sessions, other issues are more complicated or longstanding and cannot be handled within the scope of the Life-Work Connections/EAP. A Life-Work Connections/EAP counselor will assess if your issue can be resolved within the five visits you have available through the Life-Work Connections/EAP. If you have an issue that may take longer to address, it is important to start with a counselor who can continue working with you until the issue is resolved—rather than begin with one counselor and then begin again with a long-term therapist when your sessions end. If your issue cannot be handled within the number of visits available through the Life-Work Connections/EAP, your counselor will make recommendations for resources within your community that are best suited to address your needs, which may include referrals to Behavioral Health Partners services described on page 17.

Behavioral Health Partners (BHP)5

BHP offers a range of outpatient mental health services, including individual therapies and medication consultation and management. Regular full-time and part-time faculty and staff and SMH residents and fellows age 18 and older enrolled in a University Health Care Plan, as well as non-Medicare eligible retirees enrolled in a University Health Care Plan, may be eligible. Spouses, domestic partners, and dependent children of active employees or non-Medicare eligible retirees who are age 18 and older and enrolled in a University Health Care Plan may also be eligible. BHP does not provide pediatric services, and, therefore, enrolled individuals under age 18 are not eligible for BHP Plan benefits.

The cost of BHP services for University employees and dependents (age 18 and older) enrolled in a University health care plan:

- YOUR PPO Plan: Services received through BHP are not subject to the annual deductible and are covered at 100% by the Plan (i.e., there is no out-of-pocket cost).
- YOUR HSA-Eligible Plan: Services received through BHP are subject to the annual deductible and are covered at 100% after the annual deductible is met.

How Does That Make You Feel?

For more information about University emotional and mental health resources, visit www.rochester.edu/working/hr/wellness/emotional.
BHP mental health professionals include psychologists, social workers, mental health therapists, psychiatrists, and psychiatric nurse practitioners who work together in a multidisciplinary team. BHP providers also work closely with primary care providers to understand and treat the mental health needs of those served. BHP clinicians tailor the length of treatment to the mental health concerns of the individual.

BHP is a general psychiatry outpatient practice providing outpatient psychotherapy and pharmacotherapy services for persons with a primary mental health condition such as:
- Stress
- Depression
- Anxiety

Not all types of behavioral health services are covered through BHP. An initial appointment with a BHP clinician will help determine if services through BHP are right for you and will be covered under the BHP Program. Some individuals are better served with acute care or subspecialty services that are not available through BHP. BHP does not offer treatment for the following:
- A primary diagnosis of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine, or nicotine use
- Detoxification, chemical dependency, and/or rehabilitation services for alcoholism or substance dependence disorders
- Conditions for which subspecialty care is indicated due to the severity of the mental health symptoms or the need for an alternative treatment setting
- Other psychotic diagnosis not listed above and "Psychiatric emergency, inpatient treatment or suicide attempt in the past 6 months.

BHP offers telehealth therapy services. To qualify for telehealth therapy, recipients must be registered patients in BHP. The patient must provide written consent prior to the telehealth services being rendered, acknowledging that the service will be considered an evaluation and management service by the practitioner. Telehealth therapy procedures are as follows:
- The initial service will be provided in a face-to-face visit, following which telehealth-delivered services may occur.
- Face-to-face visits will be provided by the provider to the patient at least once every eight sessions.
- The length, format, and treatment goals of telehealth sessions will be identical to those of face-to-face visits.
- Telehealth-delivered services will be documented in the electronic medical record in accordance with the standards that regulate face-to-face visits.

Patients who cannot be managed safely in an outpatient setting will be evaluated for hospitalization, per standard care protocol.

For more information about BHP visit www.bhp.urmc.edu or call (585) 276-6900.

Educate yourself about available health programs and become a confident, active consumer.

Review Your 2018 Health Program Guide
This Guide outlines your Health Program benefit options and highlights other programs and services that are available to you. Review the Guide to find out how you can use your benefit Plans and programs to achieve better health and to help control health care costs.

2018 Health Care and Dental Plans Premiums Rate Sheet
The 2018 Premiums Rate sheet for both Health Care and Dental Plans offered by the University is posted on the Benefits website: www.rochester.edu/benefits. Please note the premiums are listed according to salary bands as well as employee pay cycle (bi-weekly, semi-monthly, or monthly).

Annual Indexing for Salary Banding
The University implemented salary banding to more equitably distribute health cost-sharing across all faculty and staff. The index for the University Health Care premiums are based on changes in the national average wages as reported by the Bureau of Labor Statistics. Effective January 1, 2018, the $49,000 salary band will be indexed to $50,000, and the $121,000 will be indexed to $124,000.

Health Plans Comparison Chart
The 2018 Health Plans Comparison Chart compares the benefits offered under both Plans and is designed to provide an easy to understand description of the coverage options offered to eligible faculty and staff and SMH residents and fellows. The chart is posted on the Benefits website: www.rochester.edu/benefits.

Summary of Benefits and Coverage
The 2018 coverage summaries are uniform descriptions comparing costs and coverage for each of the various benefit offerings under the University’s Health Care Plans. The summaries are posted on the Benefits website: www.rochester.edu/benefits/.
Use your health care dollars effectively and make informed decisions about what kind of care you need.

Access Online Services from the TPAs
Aetna and Excellus BlueCross BlueShield both provide an array of online services, programs, and member discounts. Here are a few of the available benefits under each TPA.

Aetna (www.aetna.com)
- Know before you go—the Member Payment Estimator is real-time based on your actual Plan. Also, use it to view the cost for procedures, tests, and prescriptions and how to manage your health.
- Health Decision Support—Finding clear and reliable health information can be tough. There is a lot of information, but it can be hard to understand. Now, you can get easy-to-understand medical information at your fingertips with Health Decision Support.
- Research over 6,000 health topics using Healthwise Knowledgebase.
- Download a Health History Report that will list your claims history or download claims to an Excel spreadsheet for easy access.
- Call Aetna’s Informed Health* Line for access to registered nurses 24 hours a day, 7 days a week.
- Locate doctors and other health care professionals in your area who participate through DocFind* at www.aetna.com/dse/custom/universityofrochester.
- Print a temporary ID card, access all of your claims, and email Member Services through Aetna Navigator.

Aetna Pharmacy (www.aetna.com)
- Use the Mail Order Pharmacy, Aetna Rx Home Delivery Mail Services, and pay less for a 90-day prescription.
- View and print your claims history.
- View a list of University Specialty Drug Pharmacies and specialty medications.
- Search for and compare prices on lower-cost drug options.

Excellus BlueCross BlueShield (www.excellusbcbs.com)
- Research over 6,000 health topics using Healthwise Knowledgebase.
- Learn to live a healthier lifestyle with Health Improvement Programs to help you change your habits.
- Use the Personal Health Record to store your health information online for easy access.
- Use the Healthcare Advisor to estimate treatment costs, evaluate treatment options, and more.
- Have fun and learn something new with weekly Health Quizzes.
- Locate doctors and other health care professionals in your area who participate in your plan through “Find a Doctor.”
- Print temporary ID cards.

Excellus BlueCross BlueShield Pharmacy (www.excellusbcbs.com/UR)
- Use the Pharmacy Locator to identify participating pharmacies in your local area.
- Use the Mail Order Pharmacy, Wegmans Home Delivery or Express Scripts Home Delivery, and pay less for a 90-day prescription.
- View and print your claims history.
- View a list of University Specialty Drug Pharmacies and specialty medications.
- Search for and compare prices on lower-cost drug options.
- Ask a licensed, clinical pharmacist your questions.

Use Member Discounts from the TPAs
- Aetna features discounts on health and wellness programs and products.
- Excellus BlueCross BlueShield offers discounts on health and wellness, family care, financial well-being, and travel services through Blue365.

Use Your Personal Health Record to Make Smart Health Care Decisions
If you are enrolled in a University Health Care Plan through Aetna, you can download a Health History Report from Aetna Navigator. The Health History Report will include details regarding any claims that you and your covered dependents have incurred under your Plan and can be exported to an Excel spreadsheet for sorting and printing.

If you are enrolled in a University Health Care Plan through Excellus BlueCross BlueShield, you and your covered dependents each have access to your own online Personal Health Record. This confidential resource will store any claims information you enter and provide you with convenient access to a range of health data. You can store your family’s health information online for easy access. And, you can print a report to take to your next doctor’s appointment or when you travel.

Don’t Have a Personal Physician? You Should. Here’s Why.

Better health. Establishing a relationship with a primary care physician (PCP) is very important when it comes to staying healthy. Visiting the same physician for preventive and regular health care is one way that you and your family can be smart health care consumers and potentially save money. Getting the right health screenings each year can reduce your risk for many serious conditions. Not only will your PCP help you take advantage of preventive care covered at 100% by the University’s Health Care Plans, a PCP is familiar with your health history and can help you determine what medical services are necessary. He/she is one of the few health care providers you’ll see both when you’re healthy and when you’re ill.

Your PCP can also help coordinate any additional care you may need to seek from multiple specialists and is responsible for keeping a record of your medical history. Therefore, it’s important to always let your PCP know if something has changed with regards to your health. For example, if you’ve been prescribed medication by two different specialists, your
PCP will be able to help you understand if there is any risk to taking both medications.

Peace of mind. Advice from someone you trust is important when you’re healthy, but it’s even more important when you’re sick. Your PCP is familiar with your health history as well as your family’s health history: this in-depth knowledge allows your PCP to be better able to determine the signs and symptoms they need to be aware of, especially if you or your family members are at risk for certain conditions. Although visiting a PCP prior to scheduling an appointment with a specialist or receiving other medical services is not required by the University’s Health Care Plans, it’s recommended to keep your PCP informed of your health concerns so they can help you and your family efficiently and effectively manage your health.

A healthier wallet. Being able to call or visit your PCP when you are sick or need medical advice helps you avoid costly and possibly unnecessary trips to an Urgent Care facility or the emergency room (non-emergency visits to the emergency room are not covered by your Health Care Plan). If you do not have a PCP and are interested in establishing this relationship, please visit your TPA’s website for information on in-network PCPs:

- Aetna: www.aetna.com
- Excellus BlueCross BlueShield: www.excellusbcbs.com/ur

A list of URMC-affiliated PCPs accepting new patients can be found at www.urmc.rochester.edu/primary-care/doctorsearch/.

You also have access to Accountable Health Partner providers, a panel of University of Rochester Medical Faculty Group providers and carefully selected community partners created to improve the health of our employees and their dependents. When you visit an Accountable Health Partner provider, you’ll receive a higher level of coverage on your out-of-pocket medical costs, plus you will have a lower deductible, copay, coinsurance, and out-of-pocket maximum.

To find Accountable Health Partners providers in your area, visit http://ahpnetwork.com/search-provider/.

Take Advantage of Prescription Drug Discounts

- You can receive discounts on your prescriptions and free delivery to most off-site University locations with daily courier service through the URMC Employee Pharmacy.
- You can also save money by asking your doctor if there are generic equivalents available for brand name drugs you may be prescribed.
- Use the mail order program for a 90-day supply prescription to get three times the supply for two and a half times the price.
- You may be eligible for discounts on prescriptions drugs used to treat a chronic condition or to save on diabetic supplies.
- Your copay for your first six months for a new generic drug will be waived when changing from a brand name to a generic drug.

For more information on your prescription drug plan and the discount programs available, see pages 36–38.
Health Program

Health Care Plans, Vision Benefits, Prescription Drug Plan, Dental Plans, FSAs, and HSA

The Plans available through the University Health Program can help you be a better health care consumer. The key is to use these Plans to change your behavior—by becoming more involved in your health, taking more responsibility for making smart health care decisions, making healthy lifestyle choices, and using your benefits wisely.

The choices you make today—whether selecting health care coverage for you and your family for the upcoming year, or deciding when and how to use health care services on a day-to-day basis—have a direct impact on the health care costs you and the University pay tomorrow.

Your Health Care Plan Choices for 2018

The University of Rochester offers two Health Care Plans that focus on features that support the University’s goals of fostering a culture of wellness, reducing health care expenses, and encouraging faculty and staff and SMH residents and fellows to take an active role in managing personal health. Take some time to understand the different Plan options available to you, so you select the Plan that is cost effective and appropriate for your needs—and those of your family.

Your Health Care Plan Options

You can choose from the following options:

- YOUR HSA-Eligible Plan
- YOUR PPO Plan

You also may choose to waive health care coverage.

How the Health Care Plans Are Alike

Both plans:

- Are either a PPO (Preferred Provider Organization) through Excellus or a Choice POS (Point of Service) II through Aetna.
- You can choose to receive care from:
  - Accountable Health Partners (tier 1)
  - Providers within the Aetna/Excellus national networks (tier 2)
  - Out-of-network (tier 3)
- Note: You may pay more for services received within the Aetna/Excellus national networks (tier 2) or out-of-network (tier 3).
- Give you access to a nationwide network of doctors, hospitals, and treatment facilities that have agreed to charge lower, negotiated rates for care. You can choose to receive care in or outside of the TPA’s network, but you may pay more for care outside of the TPA’s network.
- Allow you to visit Accountable Health Partners providers, which provide a higher benefits level with a lower deductible, copay, coinsurance, and out-of-pocket maximum than using a TPA provider who isn’t part of Accountable Health Partners.
- Do not require that you have a PCP, but it is recommended that you select one, and referrals are not required for specialists or other necessary health care services.
- Emphasize preventive care with 100% in-network coverage to encourage regular check-ups and wellness services. To learn more about preventive care, see “Coverage for Preventive Services” on page 16.

Note: All care is subject to meeting the clinical policies established by the TPA who administers your University Health Care Plan.

How the Health Care Plans Differ

The Health Care Plan options vary when it comes to what you pay for:

- Your employee contributions for the Plan option you choose, and

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6 Health care plan options for Postdocs are not described in this booklet, but rather in the separate certificate of coverage, which is hereby incorporated by reference.
Example of Embedded Family Deductible
If you are a family of four (yourself, your spouse/domestic partner, and two children), visit Accountable Health Partners providers, and you are enrolled in the YOUR PPO Plan, the deductible would work as follows:

• If you receive in-network care and satisfy the single deductible of $500, the Plan will begin to pay coinsurance for you.

• If your spouse receives health care services and satisfies his or her single deductible of $500, the Plan will begin to pay coinsurance for him or her. So far, you have applied $1,000 to the $1,250 family deductible, because the single deductibles count towards the family deductible.

• This means that when the next person in your family receives health care services, he or she only has to pay $250 before the Plan begins to pay coinsurance, because your family will have met the $1,250 deductible.

• Once the $1,250 family deductible is satisfied, all members will be subject to coinsurance with no further deductible requirements, assuming care is received in-network.

The out-of-pocket maximums follow the same pattern as the deductibles but include all copays, including pharmacy expenses in addition to eligible medical expenses. And, the deductible and out-of-pocket maximum cross apply between in- and out-of-network providers.

1 If you have one dependent on your plan (i.e., employee and spouse), you would each satisfy the single $500 deductible; the $1,250 family deductible would not apply.

Three Tiers of Benefits
The University health care plans offer three tiers of providers with different levels of coverage. You receive the highest level of benefits when you visit an Accountable Health Partners provider facility. The deductibles and out-of-pocket maximums cross apply for all three tiers. You can choose to receive care through one of the following or a combination of all three:

Accountable Health Partners Providers (Tier 1)
Accountable Health Partners is a panel of University of Rochester Medical Faculty Group providers and carefully selected community partners created to improve the health of our employees and their dependents. When you visit an Accountable Health Partners provider, you’ll have a lower deductible, copay, coinsurance, and out-of-pocket maximum than tier 2 and tier 3 providers. To find Accountable Health Partners providers in your area, call (585) 784-8855 or visit http://ahpnetwork.com/search-provider/.

TPA Network (Tier 2)
You may also seek services from providers within your TPA’s national network (either the Aetna national network or Excellus national network). Services provided at the Tier 2 Benefit Level will be subject to higher deductibles, coinsurance, copays, and out-of-pocket maximums than tier 1 providers. To find an Aetna provider, call 1-877-864-4583 or use the Doc Find tool at www.aetna.com/dse/custom/universityofrochester.
To find an Excellus BlueCross BlueShield provider, call 1-800-659-2808 or visit www.excellusbcbs.com and select Find a Doctor then click on Upstate New York Provider Network.

Out-of-Network (Tier 3)
This includes any providers who do not participate in Accountable Health Partners and your TPA network (Aetna/Excellus national networks). Services provided at the Tier 3 Benefit Level will be subject to higher deductibles, coinsurance, and out-of-pocket maximums and will be capped at the R&C levels; you may be subject to balance billing. Remember: The deductible and out-of-pocket maximum cross apply between all tiers.

• Your deductibles, coinsurance, copays, and out-of-pocket maximums when you receive care.

Additionally, the options offer different pre-tax accounts—the YOUR HSA-Eligible Plan includes the option to contribute to an HSA and a Limited Purpose Health Care FSA, while the YOUR PPO Plan allows you to contribute to a Health Care FSA.

If you enroll in the YOUR HSA-Eligible Plan but do not elect to have an HSA, you can elect to contribute to a Health Care FSA. You can only contribute to a Limited Purpose Health Care FSA if you elect to contribute to an HSA.

Deductibles/Out-of-Pocket Maximums
The YOUR PPO Plan (for inpatient, outpatient, urgent care, emergency room visits, and out-of-network care) includes embedded single deductibles within the family deductibles and out-of-pocket maximums for each of the three plan tiers. If you are enrolled in the Plan for Employee and Child(ren), Employee and Spouse/Domestic Partner, or Family coverage, once one family member satisfies the single deductible, the
Using Accountable Health Partners and TPA Network Providers

When you elect a Health Care Plan, you get to choose which TPA will administer your Plan—either Aetna or Excellus BlueCross BlueShield. No matter which TPA you choose, both options give you access to Accountable Health Partners providers.

To find out if your physician, or other providers and facilities are members of either the Aetna or Excellus BlueCross BlueShield network, visit their network directories online at:

Aetna: www.aetna.com/dse/search/?site_id=universityofrochester
Aetna’s Doc Find tool will help you determine if a specific provider or facility participates in the Aetna national network. It will also call out a subset of providers and facilities that are a part of the Accountable Health Partners provider panel.

Excellus BlueCross BlueShield
www.excellusbcbs.com
Select Find a Doctor and then click on Upstate New York Provider Network to find a local provider.

To learn more about the differences between TPAs, turn to pages 31–32. Remember, when visiting an Accountable Health Partners provider, you’ll have an even greater level of savings on cost sharing (lower deductible, copay, coinsurance, and out-of-pocket maximum). To find an Accountable Health Partners provider in your area, visit http://ahpnetwork.com/search-provider/.

Plan will begin to reimburse eligible health care expenses for that family member. If you are enrolled in two-person coverage (i.e., employee and spouse or employee and child), each member would satisfy the single deductible; the family deductible would not apply. The same rule applies to the out-of-pocket maximum; all copays, including pharmacy copays will also be covered at 100% once the out-of-pocket maximum is met. Any combination of eligible expenses for covered family members can be used to meet the family annual deductible/out-of-pocket maximum, at which point all family members will have met the deductible/out-of-pocket maximum, requirements. And, the deductibles and out-of-pocket maximums cross-apply between AHP, in-network, and out-of-network providers.

The YOUR HSA-Eligible Plan requires that the family deductible be met (for any coverage level other than Single), before coinsurance will begin for any family member.

Similarly, the YOUR HSA-Eligible Plan requires that the family out-of-pocket maximum be met (for any coverage level other than single), for Tier 1/Accountable Health Partners and Tier 3/Out-of-Network before the Plan will cover expenses at 100% for any family member. The YOUR HSA-Eligible Plan includes an embedded out-of-pocket maximum (OOPM) for Tier 2 services. There is a $6,850 embedded individual OOPM included in the family OOPM. If any individual in your family incurs $6,850 of eligible claims expenses during the plan year, the plan will pay 100% of that individual's covered expenses for the remainder of the year, even if the family has not reached the family out-of-pocket maximum.

Non-AHP Specialty Provider Services
Coverage for Ambulatory Surgical Centers, Durable Medical Equipment, Skilled Nursing Facilities, Mental Health and Substance Abuse services will be covered at the Tier 1 (AHP) cost sharing level even if the provider/facility is not part of the AHP network. However, the provider would need to participate in the Aetna/Excellus national network to be covered at the Tier 1 cost sharing level.

Please use the AHP provider search tool at www.ahpnetwork.com to identify providers within the AHP network.

1 In addition to the facility charge, physician services billed separately will be covered at the benefit tier level of the provider.

How the Plans Work
When you visit an Accountable Health Partners, Aetna, or Excellus BlueCross BlueShield provider, the Plans pay more of your expenses. Plus, under both Plans, you do not need to select a PCP or secure referrals to see a specialist or obtain other medically necessary health care services. When you visit an Accountable Health Partners provider, you will have a lower deductible, coinsurance, and out-of-pocket maximum.

Each time you receive care, you select a provider of your choice. The provider can participate as an Accountable Health Partners provider or be in-network or out-of-network based on the TPAs’ network. If you select an Accountable Health Partners, Aetna, or Excellus BlueCross BlueShield provider, you have a lower deductible, copay, coinsurance, and out-of-pocket maximum. Remember—when you visit an Accountable Health Partners provider, you will have a lower level of cost-sharing than when you visit an non–Accountable Health Partners provider within your TPAs’ network. Please refer to page 29 for more information.

What the Plans Cost You
You pay your share of the premiums for health care coverage with pre-tax dollars through automatic payroll deductions (please refer to the “Special Note Regarding Taxation of Domestic Partner Coverage” on page 10). The amount of your payroll deductions depends on whether you are paid biweekly, semimonthly, or monthly. To view the costs for each plan, visit www.rochester.edu/benefits/health.

Your employee contributions depend on whether you are full time or part time and vary by salary and coverage level. If only your salary changes midyear, you will not move to a new salary band (your employee contributions will not change). If you switch from full time to part time or vice versa, you will move to a new salary band (your employee contributions will change).

Note: The YOUR HSA-Eligible Plan includes an embedded individual out-of-pocket maximum in the tier 2 family out-of-pocket maximum. For University of Rochester retirees, the University’s share, if any, of the health care and dental premiums...
Coverage for Clinical Trials

The YOUR PPO Plan and the YOUR HSA-Eligible Plan will not deny any Qualified Individual the right to participate in an approved clinical trial as those terms are defined in the federal Public Health Service Act, Section 2709. An approved clinical trial is generally a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements. A life-threatening condition for this purpose is a disease or condition likely to result in death unless the disease or condition is interrupted.

A qualified individual is a Plan participant or covered dependent who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening condition and either:

- The referring health care professional is a participating provider and has concluded that the participant’s or beneficiary’s participation in the clinical trial would be appropriate; or

- The participant or covered dependent provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate.

The Plan will not deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the approved clinical trial. Routine patient costs include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

The Plan reserves the right to require a qualified individual to use an in-network provider participating in an approved clinical trial if the provider will accept the individual as a participant. The Plan will not discriminate against any qualified individual who participates in an approved clinical trial.
University Health Care Plans – An Overview

In 2018, you can choose between the YOUR HSA-Eligible Plan and the YOUR PPO Plan. Both Plans cover the same services and are designed to help you take control of your health and the dollars you spend on your health care. In fact, there are many similarities between the two Plans:

- Both Plans cover 100% of the cost for certain recommended preventive care services with no out-of-pocket cost to you when services are provided in-network.
- Both give you the freedom to choose your doctor. Remember, if you choose an Accountable Health Partners provider, you will usually pay less out of pocket for your care because the cost sharing is lower.
- It's your health and your decisions that affect your finances. A key difference between the Plans is when you pay. With the YOUR PPO Plan, you choose higher monthly payroll deductions for premiums and pay lower out-of-pocket dollars at the time you receive care. With the YOUR HSA-Eligible Plan you choose lower monthly payroll deductions for premiums and pay higher out-of-pocket dollars when you receive care.

Only you can decide which Plan is best for you. You owe it to yourself and your dependents to assess how you think you will use benefits in the coming year (e.g., annual physicals, medications) and determine which benefit options will help you maximize your savings while meeting your health care needs.

Key Features of Each Plan

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<tbody>
<tr>
<td>Need to meet a deductible?</td>
<td>Yes, except for preventive care services, which are covered at 100%, or for PCP or specialist office visits subject to copay or prescriptions, which are subject to copay or coinsurance, but not subject to a deductible.</td>
<td>Yes, except for preventive care services, which are covered at 100%.</td>
</tr>
<tr>
<td>Covers prescription drugs?</td>
<td>Yes, you pay your share of the copay (tier 1) or coinsurance (tier 2 and 3) until you reach the out-of-pocket maximum.</td>
<td>Yes, after the deductible, you pay your share of the copay (tier 1) or coinsurance (tier 2 and 3) until you reach the out-of-pocket maximum.</td>
</tr>
<tr>
<td>100% coverage after meeting the out-of-pocket maximum?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Use the plan with an HSA?</td>
<td>No, but you will have access to a Health Care FSA.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

YOUR PPO Plan

If you select the YOUR PPO Plan, you will:

- Have higher payroll deductions for premiums,
- Be subject to a deductible and coinsurance for inpatient, outpatient, and emergency room services; however, you will generally pay the lowest cost for services when you receive care, and
- The option to contribute to an FSA.

YOUR HSA-Eligible Plan

The YOUR HSA-Eligible Plan differs from the YOUR PPO Plan in that it has:

- Higher deductible levels,
- The option to contribute to an HSA, a tax-free savings account for medical, dental, and vision expenses, and a Limited Purpose FSA for dental and vision expenses,
- Have lower payroll deductions for premiums, and
- Special rules for the family deductible and out-of-pocket maximum (see footnote 2 on the next page).

See “A Closer Look at the HSA” on page 45 for how this plan works.
The chart below provides a high-level overview of the main features of each Plan. For a more detailed look at both plans, refer to the Plan Comparison Chart on the Benefits website.

<table>
<thead>
<tr>
<th>Plan</th>
<th>YOUR PPO Plan</th>
<th>YOUR HSA-Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aetna/Excellus National Networks</td>
<td>Aetna/Excellus National Networks</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network (Not AHP or TPA Network)</td>
<td>Out-of-Network (Not AHP or TPA Network)</td>
</tr>
<tr>
<td>Deductible (Rx included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$1,250</td>
<td>$3,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Rx and deductible included)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,500 ($2,000)</td>
<td>$3,000 ($2,500)</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000 ($4,000)</td>
<td>$9,000 ($8,000)</td>
</tr>
</tbody>
</table>

### Service Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>YOUR PPO Plan</th>
<th>YOUR HSA-Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>100%, no deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$20 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$35 copay</td>
<td>$65 copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>90%, after deductible</td>
<td>75%, after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>60%, after deductible</td>
<td>75%, after deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prescription Drugs

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>YOUR PPO Plan</th>
<th>YOUR HSA-Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail (up to 30-day supply)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Retail, Generic (up to 30-days' supply):</td>
<td>$15 copay</td>
<td>$25 copay, after deductible</td>
</tr>
<tr>
<td>Retail, Preferred Brand (up to 30-days' supply):</td>
<td>$30 copay, after deductible</td>
<td>$50 copay, after deductible</td>
</tr>
<tr>
<td>Retail, Non-PREFERRED Brand (up to 30-days' supply):</td>
<td>$120 copay</td>
<td>$200 copay, after deductible</td>
</tr>
<tr>
<td>Mail Order (up to 90-day supply)</td>
<td>2.5 times 30-day retail</td>
<td>2.5 times 30-day retail, after deductible</td>
</tr>
<tr>
<td>Prescription Diabetic Supplies and Equipment</td>
<td>You pay 10% coinsurance (no deductible; $15 maximum)</td>
<td>You pay 10% coinsurance after deductible</td>
</tr>
</tbody>
</table>

### FSA/HSA Maximum Annual Contributions

<table>
<thead>
<tr>
<th>Contribution</th>
<th>YOUR PPO Plan</th>
<th>YOUR HSA-Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA</td>
<td>N/A</td>
<td>$3,450 Single / $6,900 Family</td>
</tr>
<tr>
<td>Health Care FSA</td>
<td>$2,600</td>
<td>$2,600 (Only available if you do not open an HSA)</td>
</tr>
<tr>
<td>Limited Purpose FSA</td>
<td>N/A</td>
<td>$2,600</td>
</tr>
</tbody>
</table>

1. Deductible cross-applies in the AHP network, TPA network, and out-of-network. For the YOUR HSA-Eligible Plan, the family deductible does not contain embedded individual deductible.
2. For the YOUR HSA-Eligible Plan, it is required that the family deductible be met for any coverage level other than single, before Plan payments will begin, and similarly, the out-of-pocket maximum must be met for Tiers 1 and 3 before the Plan covers expenses at 100%. Tier 2 includes an embedded individual $6,850 out-of-pocket maximum for individuals with any coverage level except single. For the YOUR PPO Plan, individual deductibles and out-of-pocket maximums apply to any individual’s claims for family coverage. However, when the sum of any combination of individual deductibles or out-of-pocket maximums reaches the family level, the family deductible or out-of-pocket maximum will be met for all family members.
4. Full-time earning less than $50,000.
5. See page 16 for more information.
6. If you are prescribed a brand name drug when a generic equivalent exists, you will be responsible for the brand copay plus the cost difference between the brand name and generic equivalent unless the generic drug is considered to be medically inappropriate in accordance with the TPA’s medical management guidelines, such as it is ineffective, not available through a retail pharmacy, or causes dangerous side effects. Specialty drugs must be filled at your TPA’s designated specialty pharmacy. Specialty drugs do not qualify for the pricing discount available through mail order prescription.
7. 90-day supplies of maintenance drugs filled at the URMC Employee Pharmacy are eligible for a reduction in copays. Note: Expenses for out-of-network services that count toward the out-of-pocket maximum include your out-of-network deductible and the maximum reasonable and customary coinsurance amounts considered under your Plan as developed by your TPA for covered expenses. Expenses above the determined reasonable and customary costs do not count toward the out-of-pocket maximum.
Receiving Care Out-of-Country
If you will be out of the country for more than 30 days, and your TPA is Aetna, you must notify the UR Benefits Office.

Services Not Covered under the Health Care Plans
The following services are not covered under the University Health Care Plans. This list is not all inclusive. Please contact your TPA with any questions.

- Services for work-related illness or injury
- Services that are not medically necessary
- Cosmetic surgery unless medically necessary

Coverage includes reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and the prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- Custodial care
- Experimental and investigational procedures (expect as covered for clinical trials)
- Eye surgery (concerning refractive errors)
- Blood: The cost of blood, blood plasma, other blood products, or blood processing or storage charges, when they are available free of charge in the local area, except for the treatment of hemophilia when billed by a facility
- Dental (non-accidental)
- Government hospitals/facilities and programs
- Routine care of the feet
- See the TPA benefit booklets for additional exclusions imposed by each TPA.

Coverage of Transition-related Health Care Benefits for Transgender and Gender-Nonconforming Individuals
The University Health Care Plans include transition-related health care benefits for transgender and gender-non-conforming individuals. According to Aetna’s/Excellus’ policy guidelines, the benefit covers medically necessary transition-related coverage, including hormone therapy, medical and psychological counseling, and gender affirmation surgery. Cosmetic procedures are excluded. Rhinoplasty, face lifting, lip enhancement, facial-bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic. Refer to the TPA’s benefits booklet or contact Aetna or Excellus for additional information.

7 Includes: Surgery needed to improve a significant functional impairment of a body part to correct the result of an accidental injury; including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.

Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury. Note: Injuries that occur as a result of a medical (i.e., non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:

- The defect results in severe facial disfigurement, or
- The defect results in significant functional impairment and the surgery is needed to improve function

See page 52 for additional limitations due to subrogation and reimbursement rights.
Comparing the TPAs

If you enroll for coverage under the University Health Care Plans, you will need to select a TPA—either Aetna or Excellus BlueCross BlueShield. Listed below is information about the services offered by each TPA to help you choose which is right for you.

<table>
<thead>
<tr>
<th>Provider Networks</th>
<th>Aetna</th>
<th>Excellus BlueCross BlueShield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each TPA maintains their own national network of providers and reimburses them at different levels. You may want to confirm that the providers you and your family use are participating providers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| To locate a network provider | Aetna’s Doc Find tool (www.aetna.com/dse/custom/universityofrochester) will help you determine if a specific provider or facility participates in the Aetna national network. It will also call out a subset of providers and facilities that are a part of the Accountable Health Partners provider panel. | To locate an Excellus BlueCross BlueShield provider, refer to “Find Your Doctor or Hospital” at www.excellusbcbs.com. Please refer to the menu bar across the top of the home page and select the appropriate link to find a local, national, or international provider. |

| Preventive Services Coverage | Preventive services are covered at 100% if you use an in-network provider (including an Accountable Health Partners provider). To ensure 100% coverage, you should confirm that the service you are seeking is preventive, as determined by your TPA, and that your doctor will bill your TPA appropriately. All care is subject to meeting the clinical policies established by the TPA who administers your University Health Care Plan. TPAs may apply different medical management techniques and frequency guidelines for preventive care. |  |


| Prescription Drugs | When you elect a TPA, that TPA will provide your prescription drug coverage. |  |

| Drug formularies/copays | The Aetna three-tier drug formulary will be used to determine the level of copay(s) or coinsurance you will be responsible for depending on the medication prescribed. Please refer to the Aetna website listed below designated for the University of Rochester’s Pharmacy Benefits Program to identify the copay(s) and coinsurance that applies to your and/or your dependents’ medications as well as other Pharmacy Benefits program information. | The Excellus BlueCross BlueShield three-tier drug formulary will be used to determine the level of copay(s) or coinsurance you will be responsible for, depending on the medication prescribed. Please refer to the Excellus website listed below designated for the University of Rochester’s Pharmacy Benefits program to identify the copay(s) and coinsurance that applies to your and/or your dependents’ medications as well as other Pharmacy Benefits Program information. |

| www.aetna.com | www.excellusbcbs.com |  |


| Health Savings Account (HSA) | When you elect a TPA for the YOUR HSA-Eligible Plan, that TPA will administer your HSA if you elect HSA contributions. |  |

| Investing1 | Your funds are held by PayFlex and Aetna in an interest-bearing account. Current account interest rates are available online at the website listed below. There is no minimum balance required, and the monthly administrative fee is paid by the University while you are enrolled in the YOUR HSA-Eligible Plan. Alternate investment options are available once your account reaches $1,000. There are no annual investment or trading fees but transfer and closure fees apply. Log on to your Aetna Navigator™ website at www.aetna.com. | Your funds are held by HSA Bank in an interest-bearing account. Current account interest rates are available online at the website listed below. There is no minimum balance required, and the monthly administrative fee is paid by the University while you are enrolled in the YOUR HSA-Eligible Plan. Alternate investment options are available through a self-directed investment option with TD Ameritrade. No minimum account balance is required. Trading fees may apply and are available in the investment prospectus. In addition to TD Ameritrade, HSA Bank offers Devenir Investment Advisors as an option. There is an annual fee charged by the Mutual Fund Selection vendor; however, no trading fees apply. www.hسابank.com |

| Investing | |  |

| Automatic payment/debit | You will automatically receive a debit/credit card that you can use to pay for out-of-pocket expenses. You can use your debit/credit card to pay providers and pharmacies from your HSA. You can also have the following options at no cost: • Mobile app—Ability to pay a claim directly from your HSA account using the Mobile App • Online Bill Payment—An easy way to pay for expenses directly from your HSA to your doctors, hospitals, dentists, and more • Online Transfer—Transfer money to a personal checking or savings account to reimburse yourself for a paid expense. As a result of health care reform, over-the-counter medications will not be considered qualified expenses under the HSA unless you have a prescription from your doctor. If you do not have a prescription and you pay for over-the-counter medications with HSA funds, it is your responsibility to properly report the expenses as taxable on your federal tax return. | You will automatically receive a debit/credit card that you can use to pay for out-of-pocket expenses. If you use as a debit card, additional fees may apply. |

| www.aetna.com | www.excellusbcbs.com |  |

Important: Regulation for Domestic Partners and FSA/HSA Reimbursements

Your domestic partner must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA. If you use HSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent, those funds are taxable, subject to a tax penalty, and must be reported on your federal tax return.

1. The University does not endorse any particular HSA provider. This section describes the HSA providers with which the University has established an administrative relationship for contributions through University payroll. This does not constitute investment advice. You may find another HSA trustee/custodian with better investment returns on your own.
**Health Savings Account (HSA)**

<table>
<thead>
<tr>
<th>Aetna</th>
<th>Excellus BlueCross BlueShield</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you elect a TPA for your HSA-Eligible Plan, that TPA will administer your HSA. The University will pay the monthly administration fee as long as you remain enrolled in your HSA-Eligible Plan.</td>
<td>You can transfer funds to a personal account, pay bills online, or withdraw your funds by check, for a fee, by written withdrawal forms. There is a check-book fee for 50 checks and 10 deposit tickets. Fee comes out of your HSA.</td>
</tr>
<tr>
<td><strong>Withdrawing funds manually</strong> You can transfer funds to a personal account or bill pay via a check from the web or mobile app for a fee. ATM withdrawal is not available.</td>
<td>You can transfer funds to a personal account, pay bills online, or withdraw your funds by check, for a fee, by written withdrawal forms. There is a check-book fee for 50 checks and 10 deposit tickets. Fee comes out of your HSA.</td>
</tr>
<tr>
<td><strong>Account access</strong> You can manage your Aetna HSA activity online anytime, day or night.</td>
<td>You can manage your HSA activity online anytime, day or night.</td>
</tr>
</tbody>
</table>

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**Flexible Spending Accounts (FSAs)**

<table>
<thead>
<tr>
<th>Aetna</th>
<th>Excellus BlueCross BlueShield</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you elect a TPA for your University Health Care Plan, that TPA will administer your FSAs, if elected. Lifetime Benefits Solutions, Inc. is the FSA Administrator for Excellus BlueCross BlueShield. PayFlex is the FSA Administrator for Aetna.</td>
<td>If you waive health care coverage, Lifetime Benefits Solutions, Inc. will administer your FSAs.</td>
</tr>
<tr>
<td><strong>Automatic payment/debit</strong> <strong>Health, Pharmacy, and Dental:</strong> Out-of-pocket health care, pharmacy, and dental expenses will be automatically reimbursed from your FSA through Automatic Claims Transfer (ACT), including mail order through Aetna Rx Home Delivery, after the claim has been processed if a University Plan is your primary plan. (Dental expenses are sent via a special link with Excellus.) <strong>Note:</strong> The Limited Purpose Health Care FSA does not include automatic payments and debits. You will need to file your expenses manually. You may opt out of automatic reimbursement. Claims not paid through automatic reimbursement will need to be filed manually. If you cover your domestic partner, or their children on your University Health Care Plan and they are not your tax dependents, you must turn off the automatic reimbursement feature.</td>
<td><strong>Health, Pharmacy, and Dental:</strong> Out-of-pocket health care, pharmacy, and dental expenses will be automatically reimbursed from your FSA through ACT, including mail order through Wegmans Home Delivery or Express Scripts Home Delivery, after the claim has been processed if a University Plan is your primary plan. If you enroll in Medicare, you will need to manually submit claims. <strong>Note:</strong> The Limited Purpose Health Care FSA does not include automatic payments and debits. You will need to file your expenses manually. You may opt out of ACT. Claims not paid through ACT will need to be filed manually. If you cover your domestic partner, or their children on your University Health Care Plan and they are not your tax dependents, you must turn off the automatic reimbursement feature.</td>
</tr>
<tr>
<td><strong>Dependent Care:</strong> You will need to file your out-of-pocket expenses manually.</td>
<td><strong>Important: Regulation for Domestic Partners and FSA/HSA Reimbursements</strong> Your domestic partner must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA or Health Care FSA. If you use HSA or Health Care FSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent, those funds are taxable, subject to a tax penalty and must be reported on your federal tax return. The Plan may seek to recover such funds. If your domestic partner is not your federal tax dependent, and you are normally reimbursed through ACT, you are required to turn off this reimbursement feature. The same rules apply for the children of your domestic partner.</td>
</tr>
<tr>
<td><strong>Submitting claims manually</strong> Reimbursement forms are available from the UR Benefits Office or can be printed from <a href="http://www.rochester.edu/benefits/fsa">www.rochester.edu/benefits/fsa</a>. Claims can be faxed directly to 1-888-AETFLEX (238-3539). Claims are paid on a weekly basis and can be reimbursed to you by check or direct deposit. You can also submit a claim and upload receipts right from your phone with the app and your phone’s camera or directly online through Aetna Navigator and select File a Claim under Quick Links.</td>
<td>Reimbursement forms are available from the UR Benefits Office or can be printed from <a href="http://www.rochester.edu/benefits/fsa">www.rochester.edu/benefits/fsa</a>. Claims can be faxed directly to 1-888-AETFLEX (238-3539). Claims are paid on a weekly basis and can be reimbursed to you by check or direct deposit. You can also submit a claim and upload receipts right from your phone with the app and your phone’s camera or directly online through Aetna Navigator and select File a Claim under Quick Links.</td>
</tr>
<tr>
<td><strong>Minimum reimbursement</strong> There is no minimum reimbursement.</td>
<td>There is a $30 check minimum. If you have direct deposit, there is no reimbursement minimum.</td>
</tr>
<tr>
<td><strong>Account access</strong> You can also access your account directly at PayFlex via <a href="http://www.PayFlex.com">www.PayFlex.com</a> or call 1-888-678-8242.</td>
<td>To submit claims, check FSA balances, view payment information including pending claims, and reimbursements paid, log on to <a href="http://www.lifetimebenefitsolutions.com">www.lifetimebenefitsolutions.com</a>. Or, call customer service at (585) 232-2632 or 1-800-327-7130.</td>
</tr>
</tbody>
</table>

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Additional information regarding coverage available under each TPA can be found in the TPAs benefits booklets, which are available from the Benefits Office and are considered part of this SPD.
Choose the Health Plan That’s Right for You

A variety of resources are available to help guide your decision about which health Plan may provide the best coverage and value for your money.

**Choosing a TPA**
When you elect a University Health Care Plan, you get to choose which TPA will administer your Plan—either Aetna or Excellus BlueCross BlueShield. You may want to consider the network availability when choosing your TPA. The TPAs have each contracted with in-network providers to offer health care services at negotiated fees. To find out if your physician, or other providers and facilities are members of either the Aetna or Excellus BlueCross BlueShield network, visit their network directories online at:

**Aetna**
Aetna’s Doc Find tool (www.aetna.com/dse/custom/universityofrochester) will help you determine if a specific provider or facility participates in the Aetna national network. It will also call out a subset of providers and facilities that are a part of the Accountable Health Partners provider panel.

**Excellus BlueCross BlueShield**
Go to www.excellusbcbs.com and select Find Your Doctor, then National Provider Network to find a local provider. To find an AHP provider, visit the AHP website at www.ahpnetwork.com or call 1-888-457-7463.

**Cost of Care Estimating Tools**
Both Aetna and Excellus BlueCross BlueShield offer personalized cost estimator tools to facilitate Plan selection and other resources to help take the challenge out of benefits selection, make informed health care decisions, and know what you may pay out of pocket before ever making an appointment.

**Aetna**
To access the Member Payment Estimator:
- Log in to Aetna Navigator at www.aetna.com (first-time users will have to register and create an account).
- Click on “Benefits–Estimate costs” under the “See Coverage and Costs” icon on your homepage.
- Select a condition from the drop-down menu to see both in- and out-of-network costs specific to your geographical area.

**Excellus BlueCross BlueShield**
To access the Treatment Cost Advisor and Provider Selection Advisor tools:
- Go to www.excellusbcbs.com/ur and click on Excellus BCBS administers my UR Health Care Plan.
- Type in your login and password (first-time users will have to register and create an account).
- Click on For Your Health from the top navigation bar and then Decision Support Tools.

**Differences in Clinical Policy Guidelines**
Each TPA maintains its own guidelines regarding when certain services and procedures are medically necessary and appropriate. For example, the TPAs may have different rules regarding which cancer screenings are covered, at what ages and frequency, and what prior authorizations might be necessary. Some of these clinical policy guidelines are described in the separate TPA benefit booklets, and others are maintained in internal policy guidelines for the TPA’s staff. You may want to review the separate TPA benefit booklets or call the TPA’s customer service line prior to making your election if there are any particular services you anticipate needing during the plan year to understand what clinical policy or other guidelines might apply.

**Remember!**
No matter which TPA you choose, you’ll have access to Accountable Health Partners providers. Visiting an Accountable Health Partners provider gives you an even greater level of savings on cost sharing. To find Accountable Health Partners providers in your area, visit http://ahpnetwork.com/search-provider/ or call 1-888-457-7463.
Understanding how your Health Care Plan works is key to managing your health care costs effectively. The following information outlines some of the University Health Care Plan features that affect how you pay for and access your health care benefits. We encourage you to read this information carefully so you can continue to make smart health care choices for you and your family.

**Precertification**

Certain care must be precertified with the TPA before it is received. For the list of health care services that must be precertified with:

- Aetna, contact Member Services at 1-888-238-6226 or visit the Aetna website at [www.aetna.com](http://www.aetna.com)
- Excellus BlueCross BlueShield, contact Customer Service at 1-800-659-2808

### How the Plans Limit Your Out-of-Pocket Expenses

The Plans include an out-of-pocket maximum, which is a dollar limit on the most you will have to pay out of pocket for covered health care expenses. When you reach the out-of-pocket maximum—a combination of your deductible, copays, and coinsurance payments—the Plan pays 100% of covered health care and prescription drug expenses for the remainder of the year. There is an in-network and out-of-network out-of-pocket maximum for all covered services, including pharmacy expenses.

Copays/coinsurance for prescription drugs are not subject to the deductible and do not count toward the deductible under the YOUR PPO Plan. They are subject to the deductible and do count toward the deductible under the YOUR HSA-Eligible Plan. However, they are included in the out-of-pocket maximum for all Plans.

Please be aware that lower out-of-pocket maximums apply for full-time faculty and staff who earn less than $47,200 per year.

This lower out-of-pocket maximum reduces the financial impact of health care expenses for lower-paid faculty and staff and is designed to make health care costs more manageable.

**Note:** Expenses for out-of-network services that count toward the out-of-pocket maximum include your out-of-pocket deductible and the maximum reasonable and customary coinsurance amounts considered under your Plan as developed by your TPA for covered expenses. Expenses above the determined reasonable and customary costs do not count toward the out-of-pocket maximum.

### What You Need to Know About Coinsurance

If your out-of-pocket expenses exceed the deductible, coinsurance kicks in. Coinsurance is the actual percentage of health care costs paid by the Plan (either 90%, 80%, or 60% depending on whether or not services are received from AHP providers, providers within the Aetna/Excellus BlueCross BlueShield national network, or out-of-network providers).

If you live in an area without Aetna or Excellus BlueCross BlueShield network coverage, both Plans reimburse all eligible health care expenses at the in-network level.

### Filing Claims

There are no claim forms to file when you use in-network providers. You must file claim forms when you receive out-of-network care. Claim forms must be submitted within one year after the date expenses are incurred. Claim forms are available online at [www.rochester.edu/benefits](http://www.rochester.edu/benefits) (go to the Quick Links section and select Most Requested Forms). Or, you can call the number on your health care plan ID card or contact the UR Benefits Office. Follow the step-by-step instructions on the form and submit it to the address indicated on the form or your ID card.

### Save on Taxes

If you enroll in the YOUR PPO Plan, you can pay for health care expenses not covered by your Plan (except over-the-counter medications unless you have a prescription) with pre-tax dollars by contributing to a Health Care FSA. If you enroll in the YOUR HSA-Eligible Plan, you may be able to contribute to an HSA and a Limited Purpose Health Care FSA.

You may not contribute to a Limited Purpose FSA without being enrolled in an HSA. However, if you do not elect to contribute to an HSA, you may elect to contribute to a Health Care FSA. Expenses for domestic partners and children of domestic partners are not eligible for reimbursement from the HSA or FSA on a pre-tax basis unless they are your tax dependents under the Internal Revenue Code (see page 8). Turn to page 45 and see Appendix B for more information about the HSA. Turn to page 41 and see Appendix B for more information about the FSA.
Accountable Health Partners and TPA Network Doctors, Hospitals, and Facilities

These providers offer their services at discounted fees, so your coinsurance will be based on a lower dollar amount. If your doctor recommends additional care, make sure your hospitals, labs, and specialists participate in the TPA’s network. All Accountable Health Partners providers are considered in-network providers through Aetna and/or Excellus BlueCross BlueShield. Because you receive a lower level of cost-sharing when you use an Accountable Health Partners provider, you should consider visiting those providers first.

Receiving Care Out-of-Network

Out-of-network charges under both University Health Care Plans are subject to reasonable and customary (R&C) limits. Limits above R&C are also excluded from your maximum out-of-pocket accumulation. Amounts charged above R&C are not covered by the Plan and are not included in your maximum out-of-pocket accumulation. This means providers can bill you for out-of-network expenses above those limits.

For services provided by out-of-network providers, the maximum amount considered under the University Plans for payment is R&C charges. The TPA develops R&C charges taking into account pertinent factors, including:
- The complexity of the service,
- The range of services provided, and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

To avoid paying charges that exceed R&C, be sure to receive care from in-network providers whenever possible.

For services provided by or on behalf of a network physician, the R&C charge is an amount that does not exceed Negotiated Costs. (Negotiated Costs are the amount a network provider has agreed to receive from the TPAs as payment in full for covered services.)

Prescriptions Greater Than a 30-Day Supply

You may choose to fill your prescriptions at a URMC Employee Pharmacy or retail pharmacy or through your TPA’s mail order program. Please be aware that retail prescriptions are filled for a 30-day supply at a retail pharmacy. For prescriptions greater than a 30-day supply, you will need to use your TPA’s mail order program (unless you use the URMC Employee Pharmacy). If you use the mail order program or URMC Employee Pharmacy, you may save on prescription drugs. With mail order, you will pay only two-and-a-half times the price of a 30-day supply for a 90-day supply of prescription drugs, or you can receive a 90-day supply of your prescription at a reduction in copays/coinsurance through the URMC Employee Pharmacy.

Note: If you are enrolled in the YOUR HSA-Eligible Plan, you will receive the reduction in copays/coinsurance after the Plan deductible has been met. Before reaching the deductible, you will receive an applicable discount on your out-of-pocket prescription drug costs.

As a reminder, you will not be able to use your FSA to pay for over-the-counter medications, unless a prescription is provided by your doctor. Over-the-counter medications will not be considered qualified expenses under the HSA unless you have a prescription.

Additional prescription drug benefits are available. See page 37.
Your Prescription Drug Plan

The TPA—Aetna or Excellus BlueCross BlueShield—you selected for your medical coverage Plan will also provide your prescription drug coverage.

You do not need to enroll separately for prescription drug coverage. If you enroll in one of the University Health Care Plans, you will automatically receive prescription drug benefits in conjunction with your plan.

ID Cards

If you are enrolled in a University Health Care Plan, you will receive a subscriber ID card from your TPA (either Aetna or Excellus BlueCross BlueShield) that can be used for both medical and pharmacy expenses. Be sure to bring it with you when you go to a participating pharmacy, as it identifies you as having prescription drug coverage and includes information that your pharmacy needs to process your claims.

Your Prescription Drug Benefit and Copays/Coincureance

Your TPA’s (Aetna or Excellus BlueCross BlueShield) drug formulary is used to determine the copay/coinsurance for your medications. The University’s three-tier prescription drug benefit allows you to make informed choices and encourages you to select value when choosing your medications.

Both TPAs have practicing physicians and clinical pharmacists regularly review the drugs on the Three-Tier Formulary Guide. You can view this Three-Tier Formulary Guide online at www.excellusbcbs.com/ur (Excellus BlueCross BlueShield) or www.aetna.com/formulary (Aetna), or you can contact the Pharmacy Help Desk at 1-800-499-2838 (Excellus BlueCross Blue Shield) or 1-888-792-3862 (Aetna) to ask about the copay/coinsurance for your prescriptions.

The copay/coinsurances for a 30-day supply retail prescription filled through your TPA’s participating network pharmacies are as follows:

<table>
<thead>
<tr>
<th>Drug Tiers</th>
<th>Generic</th>
<th>Brand Preferred</th>
<th>Brand Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$15</td>
<td>$25 (min, $60 max)</td>
<td>$50 (min, $120 max)</td>
</tr>
</tbody>
</table>

Note: For the YOUR HSA Eligible Plan, copay/coinsurance will apply after the deductible has been met. 1. The minimum will not apply if the total cost of the drug is less than the minimum required copay.

Please note, if you are prescribed a brand name drug when a generic equivalent exists, you will be responsible for the brand copay plus the cost difference between the brand name and generic equivalent. This cost difference fee will be waived if the generic drug equivalent is medically inappropriate in accordance with the TPA’s medical management guidelines, such as it is ineffective and/or results in dangerous side effects and your health care provider indicates that the generic drug should not be dispensed. If the generic equivalent is ineffective, please have your health care provider fill out a MAC Penalty Exception Request Form. New prescriptions will require your provider to complete the form in full, or you will be charged the cost difference fee. The exception form can be accessed at www.excellusbcbs.com/ur (Excellus BlueCross Blue Shield) or www.aetna.com (Aetna), or providers can contact the Provider Pharmacy Help Desk to obtain a form at 1-800-499-2838 (Excellus BlueCross Blue Shield) or 1-800-238-6279 (Aetna).

Participating Network Pharmacies

You have access to participating pharmacies in the Excellus BlueCross BlueShield and Aetna nationwide participating pharmacy network, including national chains and independent pharmacies. You just need to show your medical ID card at any participating pharmacy to identify yourself as having prescription drug coverage.

Mail Order Pharmacy

Mail order pharmacy allows you to save money and also to have the convenience of home delivery for certain prescriptions. As a University Health Care Plan member, you will utilize the Excellus BlueCross BlueShield mail order pharmacy partner, Wegmans Home Delivery or Express Scripts Home Delivery, or the Aetna mail order pharmacy partner, Aetna Rx Home Delivery.

By using the mail order pharmacy, as a University Health Care Plan member, you will pay two and a half times the 30-day supply copay/coinsurance amounts for a 90-day supply when you order through Wegmans Home Delivery or Express Scripts Home Delivery or Aetna Rx Home Delivery. The copays/coinsurance for a 90-day supply mail order prescription through Wegmans Home Delivery or Express Scripts Home Delivery or Aetna Rx Home Delivery reflect two and a half times the 30-day supply copays/coinsurance.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Benefit (Tier 1/Tier 2/Tier 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOUR HSA-Eligible Plan</td>
<td>2.5 times retail</td>
</tr>
<tr>
<td>YOUR PPO Plan</td>
<td>2.5 times retail</td>
</tr>
</tbody>
</table>

Note: For the YOUR HSA-Eligible Plan, copay/coinsurance will apply after the deductible has been met.

The mail order program is convenient to use and is an easy way to save money on your prescription drugs. You can receive a 90-day supply of your prescription at a reduction in copays/coinsurance if you use the URMC Employee Pharmacy for each 30-day supply. If you are enrolled in the YOUR HSA-Eligible Plan, you will receive the reduction in copays/coinsurance after the plan deductible has been met. Please note, when using mail order for prescriptions greater than a 30-day supply, you should inform your physician to write a mail order prescription for a 90-day supply.
How to Get Started

If you are using the mail order pharmacy for the first time:

- Ask your doctor for a new prescription written for up to a 90-day supply. If Excellus BlueCross BlueShield is your TPA, complete the Wegmans Home Delivery order form or the Express Scripts Home Delivery order form; both are available online at www.excellusbcbs.com/ur. You can also speak to a representative from either Wegmans Home Delivery by calling 1-800-586-6910 or Express Scripts Home Delivery by calling 1-855-325-5220. If Aetna is your TPA, complete the Aetna Rx Home Delivery mail order service form, which you can access online at www.aetnanavigator.com or by calling 1-888-792-3862.
- Mail the order form and prescription to Wegmans Home Delivery or Express Scripts Home Delivery or Aetna Rx Home Delivery at the address listed on the mail order form.

For more details on how to use the Wegmans Home Delivery or Express Scripts Home Delivery or for questions regarding a mail order prescription, go to www.excellusbcbs.com/ur or contact Wegmans Home Delivery at 1-800-586-6910 or Express Scripts Home Delivery at 1-855-325-5220. For more details on how to use the Aetna Rx Home Delivery or for questions regarding a mail order prescription, go to www.aetnanavigator.com or contact Aetna Rx Home Delivery at 1-888-792-3862.

Specialty Medications

Under the University Health Care Plans, specialty drugs must be filled at a designated specialty drug pharmacy. Excellus BlueCross BlueShield and Aetna have partnered with the URMC Employee Pharmacy as the preferred specialty drug pharmacy for University Health Care Plans. Although not the preferred provider, Aetna’s Specialty Pharmacy and Excellus BlueCross BlueShield’s Accredo Pharmacy or UR Employee Pharmacy, Accredo and Walgreens are also designated specialty pharmacies. However, if you use the URMC Employee Pharmacy for your specialty drugs, you can take advantage of the discounts available. If you are enrolled in the YOUR PPO Plan, you will receive a reduction in your specialty medication cost sharing. If you are enrolled in the YOUR HSA-Eligible Plan, you will receive a discount off the usual out-of-pocket cost of your specialty medication prior to reaching your deductible and then the reduction in cost sharing once your deductible has been met.

Prescription Drug Discount Programs

URMC Employee Pharmacy

If you are enrolled in the YOUR PPO Plan, you will receive a reduction in copay/coinsurance for prescriptions filled at the URMC Employee Pharmacy.

If you are enrolled in the YOUR HSA-Eligible Plan, you will receive a discount off the usual out-of-pocket cost of each medicine prior to reaching your deductible and then the reduction once your deductible has been met. Additionally, while a 90-day supply of maintenance medication normally must only be filled through a mail order pharmacy, it can be filled at the URMC Employee Pharmacy and is eligible for the discounts stated above.

The URMC Employee Pharmacy also offers free prescription delivery through a courier service from the pharmacy located in the Medical Center to employees at most University off-site locations with daily courier service. You do not need to be enrolled in one of the University’s Health Care Plans to take advantage of this service. Payment will be limited to credit cards only and will be processed through an online system.

To look up the URMC Employee Pharmacy in the Excellus BlueCross BlueShield Pharmacy Locator tool, visit www.excellusbcbs.com/ur and go to Strong Outpatient Pharmacy. To view the URMC Pharmacy in the Aetna Pharmacy Locator tool, visit Aetna Navigator Pharmacy Locator at www.aetna.com.

Prescription Drug Discounts for Chronic Conditions

If you have asthma, diabetes, hypertension, heart disease, or congestive heart failure, you may have an opportunity to receive a discount off of your prescription drugs to treat these conditions or a discount on coinsurance for prescription diabetic supplies and equipment under the University Health Care Plans. All you need to do is enroll and complete the Condition Management Program for asthma, diabetes, hypertension, or heart disease. The discount will be effective while you are enrolled in the condition management program and, upon completion of the program, will remain in effect through the end of the calendar year.

Please note: If you are enrolled in the YOUR HSA-Eligible Plan, you must pay the full cost of prescriptions until you meet the deductible. Once met, you will then qualify for the discounted prescription drug program.

Switch to Generics

According to the U.S. Food and Drug Administration, generic drugs are the same as brand name drugs in dosage form, safety, strength, quality, and intended use. When you receive generic drugs instead of preferred brand name or non-preferred brand name drugs, you should see significant savings in your prescription drug copays/coinsurance. In fact, under some University Health Care Plans, a generic drug will cost you less than half the price of a preferred brand name drug. Additionally, if you choose a brand name drug when a generic equivalent exists, you will be responsible for the copay/coinsurance plus the cost difference between the brand name and generic equivalent, even if your doctor prescribes a brand name drug, unless the generic drug is considered to be medically inappropriate in accordance with the TPAs’ medical management guidelines, such as it is ineffective, not available through a retail pharmacy, or considered to cause dangerous side effects.

Generic Trial Program

The Generic Trial Program offers a free trial of selected generic medications for the first
six months of your prescription. The first time you fill a prescription for one of the selected generic medications included in the program, your copay/coinsurance will be waived for the first six months of your prescription. This applies to new prescriptions or a switch from an existing prescription to a participating generic prescription. All future prescriptions will be at the usual copay/coinsurance amount.

How it works:
- Ask your health care provider to write you a prescription for one of the generic medications included in the program.
- You will be permitted one free six month trial per medication.
- You are responsible for the cost of all refills and future prescriptions for the medication beyond the initial six months, which will be at the usual generic copay/coinsurance amount.

Please note: if you are enrolled in the YOUR HSA-Eligible Plan, your deductible must be met before the Generic Trial Program will apply. If you do not meet your deductible within the first six months, you will not be eligible for the discount.

To learn more about the Generic Trial Program or for a listing of the medications selected for the program, visit www.excellusbcbs.com/ur or www.aetnanavigator.com, or contact the Pharmacy Help Desk at 1-800-499-2838 (for Excellus members) or Aetna Pharmacy Management Customer Service at 1-888-792-3862 (for Aetna members).

**Prior Authorization and Step Therapy**
Prior authorization and step therapy requirements are applied to selected medications to ensure that you have access to safe and effective drug therapy.

**Prior authorization**—Your health care provider must contact Excellus BlueCross BlueShield or Aetna for approval before your prescription claim can be processed for medications requiring prior authorization.

**Step therapy**—For medications requiring step therapy, you must try a certain drug to treat your condition first before Excellus BlueCross BlueShield or Aetna will cover any other drug for that condition. Medication therapy is organized in a series of “steps” with “step one” generally being a generic or lower-cost option and “step two” being a higher-cost or brand name drug.

You can see what drugs require prior authorization or step therapy on Excellus BlueCross BlueShield’s or Aetna’s Three-Tier Formulary Guide available at www.excellusbcbs.com/ur or by contacting the Pharmacy Help Desk at 1-800-499-2838. Aetna’s Guide is available at www.aetnanavigator.com/formulary or by contacting 1-800-238-6279.

**Online Services**
Several features are available to you on the Excellus BlueCross BlueShield and Aetna websites for University of Rochester pharmacy members at www.excellusbcbs.com/ur and www.aetnanavigator.com.

- Find a Local Pharmacy—The Pharmacy Locator allows you to identify participating pharmacies within a specific distance from wherever you are within the United States by entering city and state OR zip code and selecting the distance you are willing to travel to a participating pharmacy. Directions to the pharmacy are provided and those that are open 24 hours are also identified for your convenience.
- Fill Prescriptions by Mail—Provides a link directly to your TPAs mail order service (Wegmans Home Delivery or Express Scripts Home Delivery for Excellus BlueCross BlueShield members or Aetna Rx Home Delivery for Aetna members). Create an account with Wegmans Home Delivery or Express Scripts Home Delivery or Aetna Rx Home Delivery and obtain a 90-day prescription for two and a half copays/coinsurance instead of three copays/coinsurance.
- Fill 90-day prescriptions at the URMC Employee Pharmacy and receive a discount for each 30 day supply if enrolled in the YOUR PPO Plan (and the YOUR HSA-Eligible Plan after satisfying your deductible).
- Find a Specialty Drug Pharmacy and list of specialty medications that must be obtained through either Aetna’s Specialty Pharmacy or Accredro, Walgreens, or the UR Employee Pharmacy.
- Claims History—View and print your claims history and obtain a Prescriptions Report, which includes prescription number, medication, physician, and pharmacy location.
- Search Drugs and Compare Costs—The cost of prescription drugs varies widely, even for medications that are used to treat the same condition. Several programs and resources have been developed to help you and your doctor select lower cost options that are just as effective, saving you money.

- Check drug prices
- View or print the Three-Tier Formulary Guide
- Find a list of medications that require prior authorization or step therapy
- Obtain the list of medications that are included in the Generic Trial Program

**Prescription Drug FSA Reimbursement**
If you have a Health Care FSA, you can use it to pay for prescription drug expenses; however you must pay the respective copay(s)/coinsurance at the point-of-sale, and then you will be automatically reimbursed through Automatic Claims Transfer (ACT) for expenses.

**Note:** You may opt out of ACT at any time. Claims not paid through ACT will need to be filed manually. If the University Health Care Plan is not the primary plan for your dependents, you will need to file claims manually. The Limited Purpose Health Care FSA does not include automatic payments and debits; you will need to file your claims manually.
Flexible Spending Accounts and Health Savings Account

The University offers two ways to help you save on taxes when you have eligible health care, dental, and/or dependent care expenses. They are:

- Flexible Spending Accounts (FSAs)
- Health Care FSA (for those eligible for a University Health Care Plan)
- Dependent Care FSA (for dependent day care expenses)
- Health Savings Account (HSA) (for those enrolled in the YOUR HSA-Eligible Plan)

A Flexible Spending Account (FSA)

FSAs offer you a great way to save on eligible health care or dependent care expenses. If you participate, you choose how much to contribute for the Plan Year. Each pay period, your contributions are automatically deducted from your paycheck in equal amounts—before taxes—and deposited into your FSA. Then, when you incur an eligible expense, you get reimbursed from your account. Since you are using tax-free money to pay for your eligible expenses, you reduce your taxable income, save on taxes, and increase your take-home pay.

Carrying Over FSA Funds

According to IRS rules, your elected FSA contributions can only be used to reimburse expenses incurred between January 1, 2017, and December 31, 2017. You can roll over up to $500 to the next Plan Year; however, you will forfeit any unused FSA dollars above this amount for which you have not incurred eligible expenses during that time period. You will have until April 30, 2018, to file your claims. See FSA Carryover on page 41 for additional information.

A Health Savings Account (HSA)

An HSA can help you manage your health care and save for future health care expenses. In fact, it can offset the cost of the deductible and other out-of-pocket costs of the YOUR HSA-Eligible Plan.

It also offers the potential for some significant tax advantages. Contributions you make to your HSA are tax deductible and earn interest tax-free. HSA funds also are not taxed when withdrawn to pay for qualified health care expenses.

An HSA is like having your own health care checking or savings account. How you use the funds in your HSA is entirely up to you—you can use them to pay for eligible health care expenses until you meet your deductible, or you can save them for future expenses. You will not pay federal income taxes on your HSA as long as you use the funds for qualified health care expenses.

Customer Identification Program (CIP)

The USA Patriot Act federal regulations require all banks to implement Customer Identification Programs (CIPs) to prevent financing of terrorist operations and money laundering. The following information is required and collected by your bank if you elect an HSA for CIP:

- First Name
- Last Name
- Residential Address
- Date of Birth
- Social Security Number
- Home or Business Phone

The information above is used to validate the account holder’s identity.

HSA Regulations

- You cannot be reimbursed for any health care expenses incurred before your HSA is established.
- You cannot contribute to an HSA if you are eligible to be claimed as someone’s dependent on their tax return.
- You cannot be enrolled in another health care plan—for example, through your spouse or Medicare (Parts A, B, C, and/or D).
- You or your spouse cannot enroll in a Health Care FSA through the University or another employer; however, you or your spouse may enroll in a Limited Purpose Health Care FSA through the University or another employer.
- You cannot contribute to an HSA if you or your spouse has an HRA that could reimburse your claims.
- Expenses for domestic partners and their children are not eligible for reimbursement from the HSA on a pre-tax basis unless they are your tax dependents under the Internal Revenue Code.
- Only certain types of expenses are eligible to be paid by funds in an HSA. Distributions from your HSA will be reported to you and the IRS on Form 1099-SA for all withdrawals even if they were used to pay for qualified expenses and are not taxable. If the distribution was used for a non-qualified expense, such as an over-the-counter medication, you must report that amount as income on your federal tax return and you also may be required to pay a 20% excise tax. Please consult with your tax advisor for more information.
HSA or Health Care FSA—What Is Right for You?

The University of Rochester gives you the opportunity to contribute pre-tax dollars that you can use to pay for eligible health care, dental, and vision expenses not paid for by either plan. The HSA is available when you enroll in the YOUR HSA-Eligible Plan and meet the eligibility requirements set by the IRS. The Health Care FSA is available if you select the YOUR PPO Plan or YOUR HSA-Eligible Plan (if you are not contributing to an HSA), or waive coverage. (With the YOUR HSA-Eligible Plan, if you are contributing to an HSA, you may also contribute to a Limited Purpose Health Care FSA.) The types of expenses the accounts cover are similar but not identical. Because you do not pay FICA or federal income taxes on money you contribute to these accounts, they are worth considering no matter how small your out-of-pocket expenses may be in a year. Which option—if any—is right for you? Here is a quick comparison to help you think about your decision.

<table>
<thead>
<tr>
<th></th>
<th>HSA</th>
<th>Health Care FSA</th>
<th>Limited Purpose Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans Associated with These Accounts</td>
<td>YOUR HSA-Eligible Plan</td>
<td>YOUR PPO Plan (Note: You may also enroll in the Health Care FSA if you choose not to enroll in medical coverage through the University, or if you enroll in the YOUR HSA-Eligible Plan but do not contribute to the HSA)</td>
<td>YOUR HSA-Eligible Plan, if already contributing to an HSA</td>
</tr>
<tr>
<td>Funding Maximums</td>
<td>You fund with before-tax dollars, up to a maximum of $3,450 individual/$6,900 family. In 2018, the University will provide a one-time HSA contribution of $200 individual/$400 family for full-time employees earning less than $50,000 and Residents and Fellows who enroll in the YOUR HSA-Eligible Plan during the Open Enrollment and satisfy the IRS eligibility requirements. We will also provide a prorated contribution to full-time employees earning less than $50,000 and Residents and Fellows if they are: new hires, rehires, newly eligible employees as well as employees or Residents and Fellows experiencing a qualifying event. The University will provide a one-time HSA contribution of $100 individual/$200 family for full-time employees earning between $50,000 and $124,000 and part-time employees with more than 5 years of service who enroll in the YOUR HSA-Eligible Plan during the Open Enrollment period and satisfy the IRS eligibility requirements.</td>
<td>You fund with before-tax dollars, up to a maximum of $2,600 per Plan Year, in addition to the $500 you may roll over from year to year.</td>
<td>You fund with before-tax dollars, up to a maximum of $2,600 per Plan Year, in addition to the $500 you may roll over from year to year.</td>
</tr>
<tr>
<td>Making Changes</td>
<td>You can enroll in, increase, or decrease your contributions at any time during the year but no more than once a month.</td>
<td>You may make a change during the year only if you have a qualified status change.</td>
<td>You may make a change during the year only if you have a qualified status change.</td>
</tr>
<tr>
<td>Availability of Funds for Use</td>
<td>Your contributions accrue throughout the year. You only have access to funds currently in your account.</td>
<td>Entire fund amount elected for the plan year is available for use as of January 1, regardless of when the actual funds are deposited in the account.</td>
<td>Entire fund amount elected for the plan year is available for use as of January 1, regardless of when the actual funds are deposited in the account.</td>
</tr>
<tr>
<td>Covered Expenses</td>
<td>Eligible health care expenses or noneligible expenses with a 20% penalty and FICA, while the HSA is open.</td>
<td>Eligible health care expenses incurred throughout the year.</td>
<td>Eligible dental and vision expenses incurred throughout the year and post-deductible medical expenses.</td>
</tr>
<tr>
<td>Portability</td>
<td>You can take your HSA with you if you leave the University, change your plan, or retire. You can also elect a beneficiary.</td>
<td>You cannot take your HSA with you if you leave the University; you may elect COBRA.</td>
<td>You cannot take your HSA with you if you leave the University; you may elect COBRA.</td>
</tr>
<tr>
<td>Rollover</td>
<td>Any unused funds in the account at the end of the year will roll over to the next year.</td>
<td>You may roll over $500 from one year to the next. Any unused funds in excess of $500 in the account at the end of the year do not roll over to the next year.</td>
<td>You may roll over $500 from one year to the next. Any unused funds in excess of $500 in the account at the end of the year do not roll over to the next year.</td>
</tr>
</tbody>
</table>

1. If you are age 55 or older, you may contribute an extra $1,000 through pretax payroll deductions to your account for 2018. Remember, your domestic partner must be considered your federal tax dependent in order to use HSA or Health Care FSA funds to be reimbursed for his or her health care expenses. If your domestic partner is covered on your health and/or dental plan and is not your federal tax dependent, their medical and dental expenses cannot be reimbursed by your FSA. You must contact your FSA administrator to request they cancel the automatic reimbursement feature to avoid FSA reimbursements for your domestic partner’s expenses.
A Closer Look at the Health Care FSA

Limited Purpose Health Care FSA
If you enroll in the YOUR HSA-Eligible Plan and contribute to an HSA, you are able to contribute only to a Limited Purpose Health Care FSA. This type of FSA can provide reimbursement for qualified dental or vision expenses but cannot reimburse any out-of-pocket health care expenses until the HSA deductible ($1,500 single/$3,000 family) has been met. You may also use the Limited Purpose Health Care FSA to pay preventive care expenses not covered in full by the plan.

If you elect to participate in the Health Care FSA, your minimum annual contribution is $100. The maximum amount you can contribute is $2,600.

You may only submit eligible health care expenses incurred from the date you enroll in the FSA and while you are covered under the Plan. Federal regulations limit reimbursements from your Health Care FSA to qualified expenses incurred by you or your federally qualified tax dependents through the end of the year in which they turn 26. For information on filing claims for reimbursement please refer to the TPA Comparison Chart on pages 31 and 32.

HEART Act
The Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008 covers special distribution rules for Reservists8 unused Health Care FSA funds. Certain Reservists called to active duty for at least 180 days may take a taxable distribution of any funds remaining in the Health Care FSA to avoid forfeiting the funds at year end. The maximum distribution is the amount available in the Health Care FSA (i.e., contributions minus reimbursements). Reservists who would like to request a distribution must complete a Qualified Reservists Distribution form (available from the UR Benefits Office).

Health Care FSA Carryovers of up to $500
Traditionally, IRS regulations have included a “use it or lose it” rule, under which FSA contributions could only be used to reimburse expenses incurred during the current Plan Year (January 1–December 31). However, the IRS regulators have issued guidance modifying the “use-it-or-lose-it” rule for health care flexible spending arrangements (FSA) to allow employers the option to let participants carry over up to $500 of their unused balances from one plan year to the next. Faculty and staff members and Residents and Fellows with a Health Care FSA or a Limited Purpose FSA will be able to carry over up to $500 of unreimbursed 2017 FSA dollars to the next Plan Year. (You will still be able to submit reimbursement claims for health, dental, or vision expenses incurred during the 2017 Plan Year up to April 30, 2018.)

The Plan allows you to carry over up to $500 of unused amounts remaining in your Health Care FSA at the end of a Plan Year to be used for eligible health, dental, or vision expenses incurred during the next Plan Year. This change applies only to the Health Care FSA, which includes the Limited Purpose FSA; carryovers are not permitted under the Dependent Care FSA.

The following rules will apply to carryovers under the Health Care FSA:

- No more than $500 of your unused Health Care FSA amount for a Plan Year may be carried over for use in the next Plan Year.

Example: At the end of the 2017 Plan Year, your unused Health Care FSA amount is $800. You may carry over up to $500 to reimburse 2018 Plan Year expenses. However, the entire $800 is also available to reimburse 2017 Plan Year expenses during the 2017 run-out period.

Over-the-Counter Drugs Not Eligible for Reimbursement
Over-the-counter medications are not considered eligible expenses under the Health Care FSA unless you have a prescription from your doctor. However, insulin and diabetic supplies as well as other medical supplies (e.g., bandages, contact lens solution), are still eligible. Also, the FSA Auto-Debit feature cannot be used to pay for these expenses. If you have a prescription for an over-the-counter medication you must file a manual claim for reimbursement. Similarly, over-the-counter medications will not be considered qualifying expenses under the HSA without a prescription. If you do not have a prescription and you use HSA funds to pay for over-the-counter medications, it is your responsibility to properly report the expenses on your federal tax return.

For more information on eligible medical, dental, and health-related expenses, refer to IRS Publication 502.

Submitting Claims for Out-of-Pocket Dental Expenses
Aetna members who have an FSA will have their out-of-pocket dental expenses automatically reimbursed through ACT from their FSA (if their dental coverage is through the University Dental Plans). Excellus BlueCross BlueShield will continue to process your dental claims manually.

Submitting Claims for Children
Health Care FSA: You can get tax-free reimbursements from your Health Care FSA for your children through the end of the calendar year in which they turn age 26. Your children include biological, adopted, step, and eligible foster children. Please note, this rule does not apply to distributions taken from your HSA.

HSA: Under the HSA, you can only submit a claim for a child that is considered a tax dependent, which generally means a child under age 19 (or age 24 if a full-time student). As with other non-qualified HSA expenses, if you submit a claim for an ineligible child, the distribution will be subject to income tax and possibly a 20% penalty tax. Adult children who are enrolled in YOUR HSA-Eligible Plan but are not tax dependents, may contribute to their own HSA.

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8 A Reservist is defined as a member of the United States reserve military force, including the Army National Guard, Army Reserve, Naval Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, and Coast Guard Reserve.
Assume that, during the run-out period for 2017, you submit and are reimbursed for 2017 expenses of $350. This leaves you with a carryover of $450 ($800-$350), which can be used for 2018 expenses. On the other hand, if you do not submit 2017 expenses during the run-out period, you will be able to carry over the maximum permitted amount of $500.

- Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit and will not count toward the maximum dollar limit on annual salary reductions under the Health Care FSA.

**Example:** Assume that for 2018, you elect the $2,600 maximum Health Care FSA salary reduction amount permitted under the Plan. Your election will not affect your carryover, and you can also carry over the maximum permitted amount of $500 from 2017 to 2018.

- Eligible medical expenses incurred in the current Plan Year will be reimbursed first from your unused amounts credited for the new Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount.

**Example:** At the end of the 2017 Plan Year, your unused Health Care FSA amount is $800. You elect Health Care FSA salary reductions of $2,600 for 2018. In January 2018, you submit 2018 eligible medical expenses of $2,700. The entire $2,700 will be reimbursed with the $2,600 you elected for 2018 and $150 of the $800 remaining from 2017. You will then have $650 remaining to reimburse any incurred 2017 eligible medical expenses submitted during the rest of the 2017 run-out period (ending April 30, 2018). However, $350 would remain in your 2017 Carryover ($500 maximum less the $150 already reimbursed). Thus, if you submit 2017 run-out expenses of $750 in February 2018, only $650 of these expenses can be reimbursed, and you will have no amounts remaining to reimburse 2018 expenses.

- If you enroll for a Health Care FSA for the new Plan Year, then your funds will carryover to the same type of FSA you have elected for your new contributions.

**Example:** If you were enrolled in a general Health Care FSA in 2017, but you enroll for a Limited Purpose FSA for 2018, then your remaining 2017 funds will be carried over to the Limited Purpose FSA, and will not be available for 2018 general medical expenses.

- If you are otherwise eligible for the Health Care FSA for a Plan Year but you do not make a Health Care FSA election, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year eligible medical expenses (in accordance with Plan terms).

- If you waive University Health Care Plan coverage, then your Health Care FSA funds will remain in the same type of FSA (the general Health Care FSA or the Limited Purpose FSA) that you had the prior Plan Year.

- If you enroll for University Health Care Plan coverage, then your Health Care FSA funds will carry over to the general Health Care FSA if you are enrolled in the YOUR PPO Plan option, and to the Limited Purpose FSA if you are enrolled in the YOUR HSA-Eligible Plan option.

**Note:** Under IRS rules, if you carry over any unused general Health Care FSA amounts to a general Health Care FSA for the next Plan Year, you (and any other individual whose expenses can be reimbursed by your Health Care FSA) cannot contribute to an HSA during the entire next Plan Year. Therefore, if you are not making a new FSA election and you are also waiving University Health Care Plan coverage for the new Plan Year, but you (or someone else whose expenses can be reimbursed by your Health Care FSA) would like to contribute to an HSA during the next Plan Year, then you must either waive (decline) a general Health Care FSA carryover before that Plan Year begins, or request that your remaining general Health Care FSA funds be rolled over to the Limited Purpose FSA, using a form available from the Benefits Office. If you waive the carryover, you may continue to submit claims for expenses incurred during the current Plan Year until the end of the run-out period (April 30th of the following Plan Year), to be reimbursed from your available general Health Care FSA amounts. If those claims do not use up your entire general Health Care FSA balance for the current Plan Year, any unused amounts will be forfeited in accordance with your waiver.

**Example:** Before the beginning of the 2018 Plan Year, you were enrolled in the General Health Care FSA. For 2018, you opt out of the University Health Care Plan and the University FSA because you are enrolled in your spouse’s HSA-eligible plan. You have funds remaining in your general Health Care FSA at the end of 2017 and waive the carryover so that your spouse may contribute to his/her own HSA. On December 31, 2017, you have an unused Health Care FSA amount of $300. Because of the waiver, the $300 will not be carried over to the 2018 Plan Year. However, it will remain available to reimburse expenses incurred during the 2017 Plan Year until the end of the run-out period for that Plan Year. Any unused amount remaining at the end of the run-out period will be forfeited.

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**Important: Regulation for Domestic Partners and FSA/HSA Reimbursements**

Your domestic partner must be considered your federal tax dependent in order for their health care expenses to be eligible for reimbursement from your HSA or Health Care FSA. If you use HSA or Health Care FSA funds to pay for expenses for a domestic partner who is not a qualified tax dependent. Those funds are taxable, subject to a tax penalty, and must be reported on your federal tax return. In the case of the FSA, the Plan may also recover those funds from your pay via payroll deductions. If your domestic partner is not your federal tax dependent, and you are normally reimbursed through ACT, you are required to turn off this reimbursement feature.
You must be a participant in the Health Care FSA as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.

Common Eligible Expenses
The following are common medical, dental, and health-related expenses that the Internal Revenue Service considers to be eligible FSA and HSA expenses provided that you have not been reimbursed for them through any other benefit plan(s). For the Limited Purpose FSA, only dental, vision, and preventive care expenses are eligible until you have satisfied your deductible under the YOUR HSA-Eligible Plan.

Allowable FSA and HSA expenses for you and your eligible dependents include:

- Abortion, legal
- Acupuncture (medically necessary)
- Alcoholism treatment
- Ambulance
- Artificial limbs and teeth
- Birth control pills
- Braces
- Braille books and magazines (to the extent prices exceed prices for regular books and magazines)
- Car (modifications for medical reasons)
- Contact lenses including saline solution and enzyme cleaner
- Crutches
- Dental treatments
- Diabetic supplies
- Diathermy
- Durable medical equipment
- Electrolysis or hair removal (medically necessary)
- Examination, physical
- Exercise equipment in the home (recommended to treat a specific condition by a physician)
- Eye examination
- Eyeglasses
- Fees for health club (medically necessary)
- Fees to doctors, hospitals, etc. for:
  - Anesthesiologist
  - Chiropractor
  - Christian Science practitioners
  - Clinic charges
  - Dentist
  - Dermatologist
  - General practitioner
  - Gynecologist
  - Internist
  - Midwife
  - Neurologist
  - Obstetrician
  - Ophthalmologist
  - Optometrist
  - Osteopath, licensed
  - Podiatrist
  - Practical nurse
  - Psychiatrist
  - Psychoanalyst (medical care only)
  - Psychologist (medical care only)
  - Sex therapist (medical care only)
  - Surgeon
  - Guide dog and its upkeep
  - Hair transplant (medically necessary)
- Hearing aids and batteries
- Hospital services
- HMO (Health Maintenance Organization) copayments
- Insulin
- Iron lung
- Laboratory fees
- Lead-based paint removal to prevent lead poisoning
- Legal fees to allow treatment for mental illness
- Lip-reading lessons
- Lodging for medical care
- Medical information plan (amounts paid to plan that keeps your medical information)
- Mentally retarded, special home
- Nurses’ expenses and board

Health Care Expenses That Are Not Reimbursable through an FSA OR HSA

- Expenses for ineligible dependents, per federal regulations
- Expenses incurred before the effective date of your FSA or HSA
- Certain over-the-counter medications without a prescription
- Any illegal treatment
- Cosmetic services and procedures (unless necessary to resolve normal functioning)
- Cost of remedial reading classes for non-disabled child
- Dancing or ballet, even when recommended by a doctor
- Diaper service
- Food for weight loss programs
- Funeral expenses
- Health and beauty aids
- Insurance premiums
- Medications specifically used for cosmetic purposes
- Teeth whitening

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9 Refer to IRS Publication 502 for additional information. You may also consult IRS Publication 502 for information on whether an expense qualifies as an eligible health care expense but keep in mind that you generally cannot use the Health Care FSA to pay insurance premiums or for long-term care expenses, even though they appear in Publication 502. You may also consult IRS Publication 502 for information on whether an expense qualifies as an eligible health care expense but keep in mind that you generally cannot use the HSA to pay insurance premiums (except for COBRA, Long Term Care, insurance while you are unemployed, retiree health insurance, or Medicare Part A, B, C or D premiums), even though they appear in Publication 502.

10 For claim purposes, a copy of the physician order or a letter of medical necessity must be included with the claim.
• Nursing care
• Nursing home (for medical reasons)
• Operations and related treatments
• Oxygen equipment
• Prescribed drugs and medicine
• Refractive surgery-LASIK, LASEK, PRK, CK
• Rental of medical equipment
• Sanitarium
• Smoking cessation programs
• Special schooling of physically or mentally handicapped family member
• Sterilization
• Telephone (for the deaf)
• Television equipment which displays the audio part of TV programs for the deaf
• Therapy (for medical treatment)\textsuperscript{10}
• Transplants
• Tuition fees (medical charges included in tuition for schools or stated on the bill)
• Vitamins (that require a prescription for purchase)
• Weight loss/reduction programs (physician approved)\textsuperscript{10}
• Wheelchair
• Wigs to cover baldness due to medical reasons
• X-rays
A Closer Look at the HSA (for those enrolled in the HSA-Eligible Plan)

What is unique about the YOUR HSA-Eligible Plan is the HSA. It is like a personal, tax-free savings account for health care expenses that earns interest.

- An HSA is an account solely owned and funded by you.
- You can make pre-tax contributions through payroll deductions to your HSA. The amount that can be contributed is determined by the IRS and depends on whom you cover, as shown in the chart to the right.
- Please consult with your tax advisor or the bank where your HSA is housed when considering using the account for expenses that are incurred within close proximity to the establishment of the account to ensure compliance.
- Your HSA contributions are initially invested in an interest-bearing account through the financial institution contracted by the TPA. Alternative investment options are available.11
- Your HSA grows through your tax-free contributions, interest, and possible investment returns.
- You can use HSA dollars at any time to pay for eligible health care expenses, and if you do not use all the money in a calendar year, you can carry your balance forward year to year, with no time limit for using it, allowing your HSA to grow over time. You can also use HSA dollars to pay for long-term care, COBRA premiums, health insurance premiums while unemployed, and certain future retiree health care premiums (but not Medicare Supplement premiums).
- While the HSA is established to reimburse you for health care expenses, you can withdraw the money in your account at any time. Withdrawals for health care expenses are not taxed. However, you will have to pay income tax on the withdrawal plus a 20% excise tax on any withdrawals not related to health care expenses. It is recommended that you retain receipts for all HSA withdrawals to document that each expense is eligible for tax-free treatment.

Making Contributions to an HSA
You set the amount you want to contribute when you enroll, and you can change your contribution election each pay period by completing a 2018 Benefit Program Qualifying Event Change Form available at www.rochester.edu/benefits (go to the Quick Links section and select Forms from the menu on the left).

<table>
<thead>
<tr>
<th>HSA Contribution Form</th>
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<tr>
<td>If you choose coverage for . . .</td>
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<tr>
<td>Just yourself</td>
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<tr>
<td>Yourself and eligible dependents</td>
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</tbody>
</table>

The maximum annual contribution is indexed and may change from year to year. Please note, these contribution maximums are prorated if you are covered by the YOUR HSA-Eligible Plan for less than 12 months of the current calendar year.

If you are enrolled in Family coverage in the YOUR HSA-Eligible Plan and do not have other coverage which would disqualify you from making HSA contributions, you can contribute up to the family maximum ($6,900 for both you and your spouse in 2018) even if your covered family members have other non-HSA eligible coverage.

Catch-up Contributions
If you are age 55 or older, you may make an additional $1,000 catch-up contribution each year (provided you are not enrolled in Medicare). If you and your spouse are 55 or older, are eligible to contribute to an HSA, and have established an HSA in each of your names, both you and your spouse can make a catch-up contribution of $1,000 each. If only one of you has an HSA in your name, only that individual can make a catch-up contribution. You can make these contributions through pre-tax payroll deductions or you can make contributions directly to your HSA.

- If your TPA is Aetna, you can use a contribution coupon that can be found in the employee portal on www.PayFlex.com online or you can make a contribution from the employee portal after registration is completed.
- If your TPA is Excellus BlueCross BlueShield, use a contribution ticket found on the back of your HSA statement or print a copy online at www.hsabank.com.

In 2018, the University will provide a one-time HSA contribution of $200 individual/$400 family for full-time employees earning less than $50,000 and Residents and Fellows who enroll in the YOUR HSA-Eligible Plan during the Open Enrollment and satisfy the IRS eligibility requirements. We will also provide a prorated contribution to full-time employees earning less than $50,000 and Residents and Fellows if they are: new hires, rehires, newly eligible employees as well as employees or Residents and Fellows experiencing a qualifying event.

The University will provide a one-time HSA contribution of $100 individual/$200 family for full-time employees earning between $50,000 and $124,000 and part-time employees with more than 5 years of service who enroll in the YOUR HSA-Eligible Plan during the Open Enrollment period and satisfy the IRS eligibility requirements.

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11 You may obtain better investment results from a different HSA trustee/custodian. The arrangements with certain HSA trustees/custodians do not constitute endorsements, recommendations, or investment advice.
For newly benefit-eligible faculty and staff and SMH residents and fellows, HSA participation begins the first day of the pay period following the date the enrollment form is submitted (if submitted before any applicable administrative processing deadline), the date of the appointment or change to eligibility status, or the first day of the calendar month following or coinciding with the effective date of the YOUR HSA-Eligible Plan coverage, whichever is later.

The Advantages of an HSA
The money you invest in an HSA belongs to you. You decide whether to use these funds to pay for eligible health care expenses or leave the money in the account. Benefits of an HSA include:

- **Three-way tax advantage.** An HSA offers a triple tax break—tax-free contributions, tax-free earnings on accumulated funds, and tax-free distributions for eligible health care, dental, or vision expenses. You can also make after-tax deposits on your own and deduct the amount from your income tax at tax filing time.

- **Fully portable.** You own the HSA. Your contributions and earnings help your account grow over time. Any HSA balance is yours to use on eligible health care expenses, even if you retire or no longer work at the University. You can also designate a beneficiary.

- **No limits based on income.** No matter how much you earn, if you meet the HSA qualifications, you can open an HSA.

- **Rollover.** You can roll over unused HSA monies from year-to-year with no limit.

How the HSA Works with the YOUR HSA-Eligible Plan
- You are responsible for the annual deductible. If you are enrolled for Employee and Child(ren), Employee and Spouse, or Family coverage, you must meet the family deductible before the YOUR HSA-Eligible Plan begins to pay a portion of eligible health care expenses for any enrolled family member. In addition, you must pay the full cost of prescriptions until you meet the deductible. Once met, you will then begin to pay a copay/coinsurance for generic prescriptions and coinsurance for other prescriptions.

Note: If you choose a brand name drug when a generic equivalent exists, the cost difference between the brand name and the generic equivalent will not be applied towards the Plan’s out-of-pocket maximum unless the generic drug is considered to be medically inappropriate in accordance with the TPAs medical management guidelines, such as it is ineffective, not available through a retail pharmacy, or considered to cause dangerous side effects.

- If your eligible health care expenses exceed the annual deductible, coinsurance applies—where you share the expenses with the Plan and the Plan covers a percentage of eligible health care expenses.

- If you set up an HSA and deposit tax-free dollars into that account, you have the option to use that money to pay for eligible health care out-of-pocket expenses, such as your deductible, coinsurance, and copays. You can also use other funds (e.g., taxable personal savings accounts) without touching the funds in the HSA. Unused HSA balances roll over to the following year and are yours to use regardless of whether or not you remain employed by the University. Over time, if you accumulate a sizable HSA balance, your out-of-pocket costs for health care can be dramatically reduced.

- If you reach your out-of-pocket maximum, the plan pays 100% for all covered charges for the remainder of the year, including prescription drugs.

- The University will pay the monthly administration fee for the trustees/custodians that have arrangements with the TPAs as long as you are an employee, resident, or fellow and remain enrolled in the YOUR HSA-Eligible Plan.

How Your HSA Works When You Become Medicare-Eligible
After you turn age 65, you can continue to use your account tax-free for out-of-pocket health expenses. When you enroll in Medicare (including Part A), you can no longer contribute to the HSA (if you are working, you must stop your contributions to your HSA); however, you can use your account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare (including Parts A, B, C, or D). (If you would like to contribute to an HSA, you must waive your Medicare coverage. If you are collecting Social Security benefits due to age, you cannot waive Medicare Part A coverage.) If you have retiree health benefits through your former employer and you are age 65 or older, you also can use your account to pay for your share of retiree medical insurance premiums. However, you cannot use your account to purchase a Medicare supplemental insurance or a “Medigap” policy. Once you turn age 65, you also can use your account to pay for things other than medical expenses. If used for other expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties.

Using the HSA
Contributing to an HSA is optional. If you enroll in the YOUR HSA-Eligible Plan, you are not automatically enrolled in the HSA, nor are you required to contribute to one. You may also use a Health Care FSA instead of an HSA to pay for eligible expenses, and you can establish an HSA with any HSA trustee/custodian of your choice and make direct (but not payroll) contributions to that HSA. The HSA is not a University-sponsored benefit plan. Refer to the chart: “Comparing the TPAs” on pages 31–32 for information on HSA investing, automatic payments/deb- its, submitting claims manually, and account access.

Note: Fees apply to the administration of an HSA. See pages 31–32.
**Dependent Care FSA**

The Dependent Care FSA is designed to help you reduce your taxes while you pay for dependent care expenses, which permit you and your spouse to work outside the home or to attend school on a full-time basis.

The Dependent Care FSA generally covers day care expenses for:

- Children under age 13 and
- A mentally or physically impaired spouse/domestic partner or a dependent who is incapable of caring for himself or herself (for example, an invalid parent) who lives with you at least eight hours a day. See Appendix B for full eligibility information.

Only employees who have eligible dependents are permitted to participate. If the plan learns that you have no eligible dependents, you will be automatically removed from participation in the Dependent Care FSA.

You decide in advance how much to set aside for the coming Plan Year. During the year, if eligible expenses arise, you are reimbursed with monies from your account. You can only be reimbursed up to the amount in your FSA when the reimbursement request is made. Employees with funds in a Dependent Care FSA as of December 31 can submit reimbursement requests through April 30 of the following year for qualified expenses incurred in the previous calendar year. Please refer to the chart at the bottom of the page to determine how much you can contribute annually.

Child care services will qualify for reimbursement from the Dependent Care FSA if they meet these requirements:

- The services may be provided inside or outside your home but not by someone who is your minor child, your spouse, or the child’s parent (if the child is under 13), or dependent for income tax purposes (for example, an older child).
- If the services are provided by a day care facility that cares for six or more children at the same time, it must comply with all applicable state and local laws and regulations.
- The services must be incurred to enable you, or you and your spouse if you are married, to be gainfully employed.
- The amount to be reimbursed must not be greater than your income or the combined income of an employee and spouse, whichever is lower.
- Services must be for the physical care of the child, not for education, meals, etc.

Allowable dependent care expenses include payments to the following when the expenses enable you, or you and your spouse if you are married, to be gainfully employed:

- Child care centers
- Family day care providers
- Babysitters
- Nursery schools
- Caregivers for a disabled dependent or spouse who lives with you
- Household services, provided that a portion of these expenses are for a qualifying dependent incurred to ensure the dependent’s well-being and maintenance
- Before and after school care
- Day camps

In the case of divorced or separated parents, a child is treated as a dependent of the custodial parent (the parent having custody for the greater portion of the calendar year) only.

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### Expenses That Are Not Reimbursable through a Dependent Care FSA

- Health care expenses for your dependents
- Expenses incurred before the effective date of your FSA
- Expenses for those who are not your eligible dependents
- Dependent care expenses that are provided to one of your dependents by a family member, unless the family member is age 19 or older by the end of the year and will not be claimed as a dependent
- Expenses for food and clothing
- Educational expenses, other than pre-school (if the cost of kindergarten schooling can be separated from the cost of child care, reimbursement is appropriate only for the child care portion)
- Overnight camps

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<tr>
<th>Based on your tax status . . .</th>
<th>You can set aside . . .</th>
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<tbody>
<tr>
<td>If you are single, married filing jointly, or head of household</td>
<td>A minimum of $100, up to $5,000</td>
</tr>
<tr>
<td>If you are married filing jointly and your spouse’s employer offers a Dependent Care FSA</td>
<td>A minimum of $100, up to $5,000 in total to the two accounts</td>
</tr>
<tr>
<td>If you are married filing separate returns</td>
<td>A minimum of $100, up to $2,500</td>
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</table>

Federal non-discrimination guidelines require the University to test the Dependent Care FSA to ensure that highly compensated employees, as defined under IRS guidelines, do not disproportionately contribute to the Dependent Care FSA. Highly compensated employees may have their FSA maximum contribution amount reduced if the test results do not meet federal guidelines.
Choose Your Dental Benefits

Maintaining good health starts with good habits, like seeing your dentist regularly. The University of Rochester helps you maintain your dental health by providing you with the choice of two Dental Plans. The Dental Plans are administered by Excellus BlueCross BlueShield.

Full-time and part-time faculty and staff, residents and fellows, and retirees have the choice of:
- Traditional Dental Assistance Plan
- Medallion Dental Plan

A summary of those options follows. Postdocs and 1199 SEIU members are not eligible, although Postdocs may elect insured dental coverage through Garnett-Powers & Associates.

Regardless of which Dental Plan you select, you may visit the dentist of your choice. You may save more on your dental expenses if you visit a dentist who participates with Excellus BlueCross Blue Shield. More than 600 area dentists currently participate with Excellus BlueCross Blue Shield. To view a list of participating dentists, go to www.excellusbcbs.com/ur and click the Find a Dentist link under the Your Dental Plan section in the lower right corner or call Excellus's Dental Customer Service at 1-800-724-1675 to request a print copy free of charge.

Excellus BlueCross BlueShield participating dentists will file your claim for you after each visit. If you visit a non-participating dentist, you may need to bring a claim form with you. Claim forms are available from the UR Benefits Office or Excellus BlueCross Blue Shield. Claim forms are also available at www.rochester.edu/benefits/dental.

Your out-of-pocket expenses will be based on which Dental Plan option you elect. When you use providers in the University Dental Faculty Group, you receive a 10% courtesy discount on your out-of-pocket expenses, regardless of whether you are enrolled in the Traditional Dental Assistance Plan or the Medallion Dental Plan.

Predetermination of Benefits
Under Predetermination of Benefits, both you and your dentist will know what your benefits will be under the Plan—and any out-of-pocket charges you will owe your dentist—before your treatment begins.

This procedure is available for any dental work that is expected to cost $300 or more. Your dentist will complete a Predetermination of Benefits form for you and send it to Excellus BlueCross BlueShield. After reviewing the form, Excellus BlueCross BlueShield will notify you and your dentist what the plan benefit will be for the treatment you require. Your dentist should then discuss this treatment with you.

Alternative Procedures Provision
Frequently, there is more than one way to treat a dental problem. Whether you are enrolled in the Traditional Dental Assistance Plan or the Medallion Dental Plan, Excellus BlueCross BlueShield will pay for the less costly, or alternate procedure, according to the schedule of covered dental services and supplies whenever there is a choice, providing the alternate treatment meets acceptable dental standards. If you and your dentist decide you want the more expensive treatment, you are responsible for the charges in excess of the alternative benefits paid by Excellus BlueCross BlueShield.

What the Plans Cost You
You pay for dental coverage with pre-tax dollars through automatic payroll deductions. (Please refer to the “Special Note Regarding Taxation of Domestic Partner Coverage” on page 10.) The amount of your payroll deductions depends on whether you are paid bi-weekly, semi-monthly, or monthly. To view the costs for each plan, visit www.rochester.edu/benefits/dental.

Under both the Traditional Dental Assistance Plan and the Medallion Dental Plan, for retirees and their eligible dependents, the University’s share of the total premium varies depending on the Post-Retirement Grandparent Level of the faculty or staff member.

Schedule of Covered Dental Services and Supplies

Your University Dental Plan is designed to cover preventive and diagnostic services at 100% of in-network negotiated rates, such as oral exams and cleanings twice each calendar year.

When You Can Make Changes to Your Dental Plan Coverage
You are only allowed to change your coverage during Open Enrollment, if you have a qualifying event, or a special enrollment opportunity. Refer to Appendix A to learn more.

Preventive Services (Class I)
There are no deductibles. Benefits are paid at 100% of the in-network negotiated rates for:
- Cleanings and oral exams—twice each calendar year,
- Prophylaxis (cleaning and scaling)—twice each calendar year,
- X-rays—Bitewing, twice each calendar year; Panorex or full mouth, once every three years,
- Palliative services—emergency treatment for dental pain, minor procedures,
- Fluoride treatment (twice each calendar year)—allowed to age 16,
- Sealants—once in 36 months for permanent unrestored molars, allowed to age 16.
- Space maintainers (once in five years)—allowed to age 16, and
- Fillings—treatment of cavities is allowed once per surface in 12 months. Bonding is not a covered benefit.

Basic Restorative Services (Class II & IIA)
Services are covered at 80% and subject to the deductible for:

Class II

- Fillings—treatment of cavities is allowed once per surface in 12 months. Bonding is not a covered benefit.
- Simple extraction oral surgery

12 Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment, if appropriate.
### Dental Plan Highlights

**Note:** Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment, if appropriate.

<table>
<thead>
<tr>
<th>Details</th>
<th>Traditional Dental Assistance Plan</th>
<th>Medallion Dental Plan</th>
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<tbody>
<tr>
<td>The Dental Plans allow you the freedom to see any dentist you choose. However, non-participating dentists are not obligated to accept Excellus BlueCross BlueShield’s allowed amounts as payment in full and will balance bill any amount in excess of Excellus BlueCross BlueShield’s allowed amounts. It is recommended that you request a Predetermination of Benefits prior to receiving any care expected to exceed $300 by a non-participating dentist.</td>
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<tr>
<td>Coverage for eligible faculty and staff members is effective the first of the month following your date of appointment or on the date of appointment if it occurs on the first of the month. Coverage for Residents and Fellows is effective the date of hire or appointment. Your enrollment form must be received by the UR Benefits Office within 30 days of when you become benefit-eligible.</td>
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</table>

| Cost of coverage (retirees pay premiums based on Post-Retirement Grandparent Level) | You pay a share of the premium through pre-tax payroll deductions. |

| Maximum benefit per calendar year (per participant) | $1,000 | $2,000 (For orthodontia, each eligible dependent under age 19 has a separate individual lifetime maximum of $1,500. No more than one-half of the lifetime maximum will be paid in any calendar year.) |

| Benefit Deductible1 | $50 Single/$150 Family |

| Preventive Services (Class I) (includes cleaning and exams, sealants, bitewing X-rays, space maintainers, fluoride treatments covered up to age 16, emergency palliative treatment, and dental prophylaxis) | Plan pays 100% of in-network negotiated rates, no deductible (Out-of-network claims are subject to balance billing.) | Plan pays 100% of in-network negotiated rates, no deductible (Out-of-network claims are subject to balance billing.) |

<table>
<thead>
<tr>
<th>Basic Restorative Services (Class II and IIA)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Class II (includes fillings and simple extraction oral surgery)</td>
<td>Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)</td>
<td>Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)</td>
</tr>
<tr>
<td>Class IIA (includes oral surgery, endodontics, periodontal surgery, periodontal scaling and root planning, and periodontal maintenance following surgery)</td>
<td>Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)</td>
<td>Plan pays 80% after deductible (Out-of-network claims are subject to balance billing.)</td>
</tr>
<tr>
<td>Major Restorative Services (Class III) (includes fixed prosthetics, removable prosthetics, inlays/onlays/crowns, refines/rebases, implants)</td>
<td>Plan pays 15% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td>Orthodontia (Class IV) (include orthodontia—only available for eligible dependents under age 19)</td>
<td>Not covered</td>
<td>Plan pays 50%, no deductible, up to lifetime maximum (see “Maximum benefit per calendar year” above). Orthodontia benefits are available only under the Medallion Dental Plan for eligible dependents under age 19. Enrollment in the Medallion Plan must be maintained during the entire course of the orthodontia treatment.</td>
</tr>
</tbody>
</table>

| Predetermination of Benefits | Yes (Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment.) | Yes (Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment.) |

1. Individual deductibles are embedded within the family deductible.

### Class IIA
- Oral surgery13
- Endodontics
- Periodontal surgery
- Periodontal scaling and root planing
- Periodontal maintenance following surgery

### Major Restorative Services (Class III)

Services are reviewed for medical necessity and are covered at 15% under the Traditional Dental Assistance Plan and 50% under the Medallion Dental Plan, subject to the deductible for:
- Fixed prosthetics
- Removable prosthetics
- Inlays/onlays/crowns
- Relines/rebases
- Implants14 (limited coverage requires preauthorization)

- Prosthodontics

Benefits are subject to the following provisos unless otherwise noted:
- These Plans provide benefits for amalgam and composite restorations in connection with treatment of decay and replacement fillings. If other techniques or materials are selected, such as crown, veneer, inlay, or onlay, it is considered optional and, if provided, should be done with the agreement of the patient to assume additional cost.
- Benefits will be paid for replacing an existing inlay/onlay or crown only if the initial placement of the restoration is over five years old.

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13 The University Health Care Plan will provide coverage for certain medical treatments. Refer to your SPD for more information.

14 Benefits for replacement of multiple missing teeth and/or bilaterally missing teeth are allowed as a partial denture.
years old. Benefits for upgrading existing fillings to an inlay/onlay or crown are limited to the allowance for a filling.

**Note:** Benefits considered for all covered prosthodontic treatment (fixed or removable) are subject to the following provisions unless otherwise noted:

- Benefits are paid for prosthodontic appliances which are needed to replace natural teeth which are lost while you are covered under either Dental Plan option.
- Benefits will be paid for charges to replace existing dentures or other covered appliances which are over five years old since the initial placement and cannot be made serviceable.
- Benefits will be paid for the repair and rebasing of existing dentures which have not been replaced by a new denture.
- If you receive a temporary denture or other device and then receive a permanent one, benefits will be paid only for the permanent one.
- No benefits will be paid for specialized techniques involving precision attachments, personalization, or characterization.
- No benefits will be paid for charges for the adjustment of dentures or other appliances within six months of their installation (charges for adjustments are normally included in the fee for installation).
- Benefits for replacement of multiple missing teeth and/or bilaterally missing teeth are allowed as a partial denture.
- Benefits for porcelain/resin (white) material placed on molar teeth are limited to the allowance for metallic material.

**Orthodontia (Class IV)**

Services are covered at 50% and subject to the orthodontia lifetime maximum. No more than one-half of the lifetime maximum will be paid in any calendar year. Deductible does not apply.

**Dental Services and Supplies Not Covered**

The following services and supplies are not covered unless otherwise noted under any section of these benefits:

- Treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician,
- Services and supplies cosmetic in nature,
- Facings on pontics or crowns posterior to the second bicuspid,
- Replacement of a lost, missing, or stolen prosthetic device,
- Replacement of a prosthetic device which is less than five years old or one that can be made serviceable,
- Training in or supplies used for dietary counseling, oral hygiene, or plaque control,
- Procedures, restorations, and appliances to increase vertical dimension or to restore occlusion, including occlusal mouth guard appliances,
- Services and supplies in connection with injury caused by war whether declared or not, or by international armed conflict,
- Services and supplies furnished in a U.S. government hospital,
- Services for which you would not be required to pay if there were no insurance,
- Certain courses of treatment that began before you were covered by the University Dental Plan (Excellus BlueCross BlueShield will determine what portion of the charges, if any, will be covered),
- Services and supplies furnished in connection with injuries or disease sustained while engaged in any occupation for remuneration or profit for which Workers’ Compensation or similar benefits are payable,
- Services and supplies to dependents who are covered under their own University of Rochester Plan,
- Services provided by a member of your immediate family or relative by marriage

**Services Covered by Both Dental Plans**

**Preventive Services**

- Oral exams—twice each calendar year
- Prophylaxis (cleaning and scaling)—twice each calendar year
- X-rays
  - Bitewing—twice each calendar year
  - Panorex or full-mouth—once every three years
- Emergency palliative treatment
- Fluoride treatment (twice each calendar year)—allowed to age 16
- Space maintainers (once in five years)—allowed to age 16
- Sealants—unrestored, permanent molars, once in 36 months, allowed to age 16

**Basic and Major Restorative Services**

- General anesthesia
- Restorative—basic (e.g., fillings)
- Endodontics (e.g., root canal therapy)
- Periodontics (treatment of supporting structures; e.g., gums)
- Oral surgery
- Implants (limited coverage requires preauthorization)
- Restorative—major (e.g., crowns, inlays)
- Prosthodontics (providing artificial replacements for teeth)—installation and maintenance

**Covered only under the Medallion Dental Plan**

- Orthodontia—allowed to age 19
Choose your Vision Benefits

New for 2018, the University is offering eligible employees the option to enroll for voluntary supplemental vision benefits through the VSP Vision Plan. The VSP benefits are separate from and in addition to the vision benefits embedded in the YOUR PPO Plan and YOUR HSA-Eligible Plan options under the health care plan.

Full-time and part-time faculty and staff, residents and fellows, 1199 SEIU members, and retirees have the option to enroll for the VSP Vision Plan. Postdocs are not eligible.\(^\text{16}\)

What the Plan Costs You

You pay for VSP Vision Plan coverage with pre-tax dollars through automatic payroll deductions.

Details of the VSP Vision Plan are described in the certificate of coverage. A high level summary of those benefits follows:

If you change to an ineligible status (Leave of Absence, Long-Term Disability, Layoff, Worker’s Compensation, NYS Paid Family Leave), coverage for VSP Vision Care is suspended. If you return actively at work, your coverage will be reinstated at that time.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Copay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellVision Exam</td>
<td>Focuses on your eyes and overall wellness</td>
<td>$20</td>
<td>Every calendar year</td>
</tr>
</tbody>
</table>
| Prescription Glasses | • $200 allowance for a wide selection of frames  
• $220 allowance for featured frame brands  
• 20% savings on the amount over your allowance  
• $110 Costco® frame allowance | Included in Prescription Glasses | Every calendar year |
| Frame | • Single vision, lined bifocal, and lined trifocal lenses  
• Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every calendar year |
| Lenses | • Standard progressive lenses  
• Premium progressive lenses  
• Custom progressive lenses  
• Average savings of 20-25% on other lens enhancements | $55  
$95–$105  
$150–$175 | Every calendar year |
| Lens Enhancements | • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. | $20 | As needed |
| Contacts (instead of glasses) | • $200 allowance for contacts; copay does not apply  
• Contact lens exam (fitting and evaluation) | Up to $60 | Every calendar year |
| Diabetic Eyecare Plus Program | • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.  
• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.  
• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam  
• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities | $15.82 Member + spouse · $16.94 Member + child(ren) · $27.06 Member + family |

Existing Savings

Glasses and Sunglasses

Retinal Screening

Laser Vision Correction

Your Monthly Contribution

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you’ll receive a lower level of benefits. Visit vsp.com for plan details.

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\(^{16}\) Postdocs are eligible for a separate vision benefit plan through Garnett-Powers. The details of the Garnett-Powers vision plan for Postdocs are not described in this booklet, but rather, in the separate certificate of coverage, which is hereby incorporated by reference.

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VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization’s contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Brands/Promotion subject to change.

Savings based on network doctor’s retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.
Important Things to Know

Important Things to Know About the University Health Care, Prescription Drug, Dental, Vision, and FSA Plans

If You Have Other Benefits Coverage
If you or an eligible dependent are covered by another employer or organization’s health care, prescription drug, or dental plan, benefits from the University’s Plans must be coordinated with those payable from other plans. To determine how the University Health Care, Prescription Drug, and Dental Plans will pay benefits when you have other coverage, the University follows a Maintenance of Benefits (MOB) provision.

The intent of MOB is to pay benefits that will not exceed the normal level of benefits that would have been payable under the plan with the highest benefits.

If the benefits of the primary plan are less than the normal benefits of the secondary plan, then the secondary plan will pay the difference between the primary plan’s benefit and the secondary plan’s normal benefit.

If the benefits of the primary plan pay the same or more than the normal benefits of the secondary plan, then the secondary plan pays nothing.

When claims are made under any of the University’s Plans and you also have coverage from another employer or group plan, the University determines which plan has the primary (or secondary) responsibility to pay for the expenses.

Subrogation and Reimbursement
Once the plan pays a benefit on your behalf, the plan will be subrogated (stand in the place of) all rights of recovery you have against any responsible party with respect to any payment made by the responsible party to you due to your injury, illness, disability, or condition, up to the full amount of the plan benefits paid.

In addition, if you receive any payment from any responsible party or insurance coverage as a result of an injury, illness, or condition, the plan has the right to recover from, and be reimbursed by, you for all amounts the plan has paid and will pay as a result of that injury, illness, disability, or condition, up to and including the full amount you receive from any responsible party.

See the TPAs benefit booklets for more information regarding the plan’s subrogation and reimbursement rights.

These guidelines determine which plan pays benefits first:
- The plan covering a person as an employee pays first.
- The plan of the parent whose birthday comes first in the calendar year pays for covered dependent children first.
- If parents are divorced, the plan of the parent with legal custody pays first, the plan of the spouse of the parent with legal custody pays next, and the plan of the parent without legal custody pays last (unless specified otherwise in a court decree).
- The plan without a Coordination of Benefits provision always pays first.
- If none of the above applies, the plan covering the person for the longest time pays first.

Qualified Medical Child Support Orders
In divorce and other domestic relations proceedings, certain court orders (and orders issued through a state-approved administrative process) may require health care coverage for your child. This is known as a Qualified Medical Child Support Order (QMCSO), and it could affect the cost of your benefits.

The QMCSO may not require the health care plan to provide coverage for any type or form of benefit not otherwise provided under the Plan. Eligible dependents will be enrolled for Health Care Plan coverage when a completed enrollment form and a copy of the QMCSO are received by the UR Benefits Office. Please note, if you do not have health care coverage, and you fail to elect coverage, you and any child(ren) named in the QMCSO will be defaulted into the YOUR HSA-Eligible Plan. Participants and beneficiaries can obtain a copy of the University of Rochester QMCSO procedures, without charge, from the UR Benefits Office.

Designation of Primary Care Providers and/or OB/GYN
Some of the plan options require or permit the designation of a primary care provider. You have the right to designate any primary care provider who participates in your TPAs network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, contact the Plan Administrator at (585) 275-2084 or the TPA listed on page 4.

Genetic Information Non-discrimination Act (GINA)
The Genetic Information Nondiscrimination Act of 2008 prohibits the University from using employees’ and family members’ genetic information in deciding eligibility and contributions for group health Plan benefits. In addition, the University cannot use genetic information for underwriting purposes.
You do not need prior authorization from your TPA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional or the health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at (585) 275-2084 or the TPA listed on page 4.

Women’s Health and Cancer Rights Act
All of the University health care plans cover mastectomies and related procedures (subject to any applicable deductibles, coinsurance, or copays). Under federal law, all group health plans that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the Plan or coverage. See page 29 for deductible and coinsurance requirements.

Notice of Medical Plan Grandfather Status under the Patient Protection and Affordable Care Act
The University of Rochester believes that the EAP is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act” or health care reform). As permitted by this law, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to University of Rochester, the Plan Administrator, at (585) 275-2084. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Maternity and Newborn Infant Coverage
Under federal law, none of the group health plans offering maternity or newborn infant coverage may 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 normal vaginal delivery, or less than 96 hours following a Cesarean section, or require that a provider obtain authorization from the Plan or the insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

Mental Health Parity Act
The Mental Health Parity Act generally requires that any services received for mental health care and treatment of substance abuse disorders are covered the same way as services for physical illnesses. This means that copays, deductibles, and coinsurance for doctor visits and hospital stays are comparable for both kinds of care.

The Act also requires the plan to provide out-of-network coverage for mental health and substance abuse disorder benefits, if out-of-network coverage is provided by the Plans for medical and surgical benefits.

Family Medical Leave Act
The Family Medical Leave Act provides job-protected time off for birth, adoption, placement of a child, your own serious medical condition, a qualifying exigency related to a family member’s active military duty, or to care for a spouse, son, daughter, parent, or next of kin who is a covered service member with a serious illness or injury. Group health plan (health care, dental, vision, health FSA, EAP, etc.) coverage will be continued for an approved Family Medical Leave if you are a regular full-time or part-time staff or faculty member or an SMH Resident or Fellow and are covered by a Health Care and/or Dental Plan at the time your absence begins. FMLA (Family Medical Leave Act) continuation rights end on the earlier of the day you return to active employment or the end of the maximum 12-week FMLA leave (26 weeks in the case of care for a covered service member with a serious injury or illness).

Additional continuation rights apply under the New York Paid Family Leave Benefits Law.

Refer to “How Your Coverage is Affected” on pages 61–63 for more information.
The Plan will make available to participants, beneficiaries, or providers, upon request, the criteria for medical necessity determinations and the reasons for any denial of reimbursement or payment for services with respect to mental health or substance abuse disorder benefits.

**Health Care Plan Coverage While on the Long-Term Disability Plan (LTD)**

For faculty and staff on LTD, Medicare will become the primary payer for health care expenses for individuals covered under a University Health Care Plan who are eligible for Medicare. The University Health Care Plan will be the secondary payer. Individuals will need to enroll in Medicare Parts A and B as of their Medicare-eligibility effective date. Even if you do not enroll in Medicare Parts A and B by the date you first become eligible for Medicare, you will automatically be enrolled in the LTD Carve-Out Medicare Plan option as of that date, and the plan will offset your benefits as though you had enrolled in Medicare Parts A and B and Medicare was paying primary from that date forward.

**Lifetime Limits**

The health care plans do not impose a lifetime limit on essential health benefits (as defined in guidance and regulations issued by the Department of Health and Human Services).

**Special Extended Coverage for Certain Adult Children**

Your adult children, who are not otherwise eligible for coverage under your University Health Care Plan (see “Who is Eligible for Benefits” on page 7) because they have attained age 26, may be eligible to elect continuation coverage through age 29 under the University Health Care Plan. Eligible adult children are those who:

- Are under age 30;
- Are unmarried;
- Live, work, or reside in the state of New York or the service area of the TPA;
- Are not covered by Medicare; and
- Are not covered by or eligible for health insurance coverage through another employer’s group health plan (e.g., their own employer’s plan or the plan of their other parent’s employer).

Coverage for the adult child will be issued as stand-alone coverage. All cost-sharing requirements and limitations will apply separately and will not be combined with those under the faculty or staff member’s or SMH Resident’s or Fellow’s policy. Consequently, covered expenses incurred by the adult child will not contribute to family deductibles and out-of-pocket maximums, nor will family-incurred expenses contribute to the adult child’s deductibles or out-of-pocket maximums.

To enroll for coverage, you and/or your child will need to complete an enrollment form and may be asked to verify the child’s state of residency or other requirements for this coverage. Enrollment opportunities are available at the following times:

- Within 60 days prior to or following the date the child’s coverage under the University Health Care Plan ends due to age;
- Within 60 days of meeting the eligibility criteria for adult child status, when coverage for the child under the University Health Care Plan had previously terminated (e.g., within 60 days of moving back into New York State, losing employer coverage, divorce, etc.);
- During the University’s annual Open Enrollment period.

The adult child or covered faculty or staff or SMH Resident or Fellow will be required to pay 100% of the cost of the coverage on an after-tax basis. The coverage must be paid for fully in advance of a month of coverage.

The faculty or staff member or SMH Resident or Fellow must continue University Health Care Plan coverage in order for the child to be covered.

This coverage will end if your child marries; lives, works, or resides outside of New York or the service area of the TPA; becomes covered by Medicare; or becomes eligible for coverage through an employer’s group health plan. You or your child must notify the UR Benefits Office in writing if your child experiences any of these situations. Coverage may also end if your child fails to pay premiums on time or for other reasons that would cause a loss of coverage under the University Health Care Plan.

**Note:** The qualifying event for purposes of counting the 36 months of available continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) occurs at the time the child originally lost coverage under the University’s Health Care Plan. For the first 36 months after the qualifying event, this special adult child coverage, if elected, will also be treated as continuation coverage under COBRA.

**You Elect COBRA Continuation Coverage**

You may have a right under COBRA to continue to participate in the group health plan options available under the Plan after you would otherwise lose coverage by continuing to make payments to the Plan, plus an administrative charge, on an after-tax instead of a pre-tax basis. COBRA is a temporary extension of coverage under the Plan. This notice generally 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 may become available to you when you would otherwise lose your group health coverage. It is available to other members of your family who are covered under the Plan in certain circumstances where they would otherwise lose their group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator. 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. For more information about the Marketplace options available, visit the New York State Health Plan Marketplace (the “NY Marketplace,” also known as the “New York State of Health”). You can access the NY...

**Important Things to Know**

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What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan 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 occurs and any required notice of the event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You will be notified at the time you are offered COBRA continuation coverage of the amount and the date payment is due.

Who Is Entitled to Elect COBRA?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your hours of employment are reduced, 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 under the Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- 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 a dependent child.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days after the later of the date of the event or the date the individual would lose coverage under the Plan. The dependent or representative will be provided with instructions for continuing their portion of coverage.

If notice is not received within that 60-day period, all qualified beneficiaries will lose their right to elect Cobra.

You must provide written notice to:

University of Rochester
Benefits Office
44 Celebration Dr.
Suite 2300
Rochester, NY 14627

Please include evidence of the qualifying event (e.g., certified copy of the divorce decree, court order of legal separation, dependent birth certificate, etc.).

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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage lasts for up to a total of 36 months.
coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally can last for only up to a total of 18 months. COBRA continuation coverage for the EAP will be provided automatically and free of charge.

Disability Extension of 18-Month Period of Continuation Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee’s termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee’s termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee’s termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). This notice must be made in writing and must include a copy of the Social Security Administration’s determination letter. This notice must be sent to:

University of Rochester
Benefits Office
44 Celebration Dr.
Suite 2300
Rochester, NY 14627

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:

- The date of the Social Security Administration’s disability determination;
- The date of the covered employee’s termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee’s termination or reduction of hours.

You must also provide the Social Security Administration’s notice to the Plan Administrator within 18 months after the covered employee’s termination of employment or reduction of hours in order to be entitled to a disability extension. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee’s termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration’s determination. If you do not notify the Plan Administrator, the plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after the first day of the month beginning 30 days after the Social Security Administration determines that the disabled qualified beneficiary is no longer disabled.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent 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 dependent 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 dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Special Rules for Health FSAs

In the case of the Health Care Flexible Spending Accounts, COBRA will be available only for the Plan Year in which the qualifying event occurs; COBRA coverage for the Health Care Flexible Spending Accounts ceases at the end of the Plan Year and cannot be continued for the next Plan Year.

If at the time of the COBRA election the Participant has already submitted more in Health Care Flexible Spending Account claims than the participant has contributed to the account (an “overspent account”), COBRA will not be offered.

How Do I Elect and Pay for COBRA Continuation Coverage?

COBRA coverage must be elected by completing election forms and submitting them to the COBRA administrator by the deadline indicated on the form, which is generally 60 days from the later of the date the forms were received or when a qualified beneficiary would lose coverage as a result of the qualifying event.

If COBRA continuation coverage is elected, the qualified beneficiary must pay the initial premium (including all premiums due but not paid) within 45 days after the election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. The cost of COBRA coverage is 102% of the full cost of Plan coverage (without any employer subsidy).

If you elect COBRA continuation and then fail to pay the premiums due within the initial 45-day grace period or fail to pay any subsequent premium within 30 days after the date it is due, coverage will be terminated retroactively to the last day for which timely payment was made. Any unused balances will not be available for reimbursement after the end of the reimbursement deadline described in this SPD.

What Happens if Plan Coverage Changes During the Continuation Period?

If coverage under the Plan is changed for active employees, the same changes will apply to individuals on COBRA continuation coverage.
What Happens if I Give Notice of an Event but I Do Not Qualify for COBRA?
If the Plan Administrator receives notice of an event that it determines is not a qualifying event or receives notice with respect to an individual that the Plan Administrator determines is not a qualified beneficiary, the Plan Administrator will provide written notice of unavailability of COBRA continuation coverage to the affected individual within the time periods required for COBRA Election Notices. The notice will be written in an understandable manner and will explain why COBRA coverage is not available.

Do I Have to Keep Family Coverage if That Is the Coverage Level I Had when Covered Due to Active Employment?
No. You may elect the same level of coverage or any lower level of coverage (e.g., you may elect Employee only, Employee and Spouse, Employee and Child(ren), or Family coverage). Unless otherwise elected, all qualified beneficiaries who were covered under the Plan will be covered together. However, each qualified beneficiary may alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate deductible, out-of-pocket maximum and a separate premium for coverage.

What Happens if I Waive COBRA and Later Change My Mind?
Qualified beneficiaries who reject COBRA continuation coverage before the Election Form due date may revoke their waiver by furnishing a completed COBRA Election Form before the due date. However, qualified beneficiaries who change their mind and revoke their waiver after first rejecting COBRA continuation coverage will begin COBRA continuation coverage on the date the qualified beneficiary furnishes the completed COBRA Election Form and will not receive coverage retroactive to the date of the qualifying event.

Are There Circumstances when COBRA Coverage Might Terminate Early?
Yes. Continuation coverage will be terminated before the end of the maximum period if:
- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;
- The University ceases to provide any group health plan for its employees.
- Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or covered dependent not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under another group health plan coverage. The Plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after the event that allowed early termination of COBRA coverage if the qualified beneficiary does not notify the Plan Administrator immediately of such coverage.

In the event of early termination, the Plan Administrator will provide the qualified beneficiaries with written notice as required by COBRA. The notice will be furnished as soon as practicable following the Plan Administrator’s determination that continuation coverage will terminate, will be written in an understandable manner, and will contain the following information:
- The reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event;
- The date of termination of continuation coverage; and
- Any rights the qualified beneficiary may have under the Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

Are There Other Coverage Options Available?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Federal Marketplace or the NY 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it’s important that you choose carefully between COBRA continuation coverage and other coverage options, because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

What Is the Health Insurance Marketplace?
The Health Insurance Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Federal Marketplace for your state at www.HealthCare.gov.

Coverage through the Federal Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Federal Marketplace.

Certain states have their own marketplaces, while other states use the Federal Marketplace. If you live in New York State, you may purchase insurance through the NY Marketplace. New York residents should contact the NY Marketplace at
When Can I Enroll in Marketplace Coverage? You always have 60 days from the time you lose your job-based coverage to enroll in Marketplace coverage. That is because losing your job-based health coverage is a “special enrollment” event. After 60 days your special enrollment period will end, and you may not be able to enroll, so you should take action right away. In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov (or https://nystateofhealth.ny.gov/ for the New York Marketplace).

If I Sign Up for COBRA Continuation Coverage, Can I Switch to Coverage in a Marketplace? What if I Choose Marketplace Coverage and Want to Switch Back to COBRA Continuation Coverage? If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful—if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period. You always have 60 days from the time you lose your job-based coverage to enroll in another group health plan within 30 days of the loss of coverage. If you or your dependent elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What Factors Should I Consider When Choosing Coverage Options? When considering your options for health coverage, you may want to think about:

- **Premiums:** The University Health Care Plans can charge up to 102% of total Plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you’re currently taking medication, a change in your health coverage may affect your costs for medication—and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas—so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area or other similar limitations.

Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums but a much higher deductible and higher copayments. Also, if you have already satisfied your deductible through the University Health Care Plans for the Plan Year, you may want to wait to enroll in Marketplace coverage until the next Open Enrollment period or else you may have to pay a new deductible.

If You Have Questions Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified on pages 4 and 5. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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.)

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.

HIPAA Privacy Rights The Plan has responsibilities under the Health Insurance Portability and Accountability Act (HIPAA) regarding the use and disclosure of your protected health information (PHI).
Your PHI is any information that: (i) identifies you, or may reasonably be used to identify you including genetic information; (ii) is created or received by a health care provider, health Plan, employer, or health care clearinghouse; and (iii) relates to your past, present, or future physical or mental health or condition or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices or you want to file a privacy violation complaint, please contact:
University of Rochester
Benefits Office
44 Celebration Dr.
Suite 2300
Rochester, NY 14627

Costs of Plan(s) and Ownership of Rebates

Employees pay the share of any Plan’s premiums and expenses as specified in the annual enrollment materials. The University pays the balance of any premiums and administrative expenses out of its general assets. Where applicable, employee premiums are paid on a pre-tax basis through the University of Rochester Cafeteria Plan and Flexible Spending Account Plan. Neither the Plan nor any of the component benefit programs offered through it have a trust.

Effective January 1, 2018, to the extent any Plan generates Medical Loss Ratio or other rebates, those rebates are attributed to the University’s share of the premiums and are not considered plan assets attributable to employee premium contributions, except to the extent otherwise required by ERISA or other applicable law.

Medicare Secondary Payer and IRS Information Reporting

You may get a letter from the University of Rochester asking you to confirm or provide Social Security number information for your covered spouse or dependents. Medicare requires the University Health Care Plans to provide this information electronically through the TPAs. Historically, we only requested the information for your spouse or dependent who is over age 45 or who was known to be covered by Medicare. Under the Affordable Care Act, we need Social Security numbers for all enrolled dependents to comply with new IRS requirements. To view the CMS (Centers for Medicare and Medicaid Services) ALERT, which provides information on the authority for requesting the Social Security number, visit https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Alerts.html. Go to the Downloads section and select the June 23, 2008, ALERT. The University will provide Form 1095-C to employees; Form 1095-C will be used to provide health coverage and enrollment to the IRS.

Uniformed Services Employment and Reemployment Rights Act

If you leave the University to perform military service, you may be protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Among other things, you may be able to elect up to 24 months of continued health Plan coverage at your expense.

If you will be leaving to perform military service, you should contact the UR Benefits Office as soon as possible to make arrangements for continued benefits. For more details on how military leave affects your employment, see HR policy #336. Also, see “How Your Coverage Is Affected” on pages 61–63.

Anti-assignment Provision

Except for voluntary assignments to health care providers, as may be required by law or as may be provided in applicable policies, your right to receive benefits under any of the Plans covered by this summary may not be assigned, voluntarily or involuntarily, to any other person. A medical service provider has no standing to bring a claim for benefits with respect to services it provides to a plan participant.

Amendment and Termination

The University has adopted these plans with the intention of them being maintained for an indefinite period of time. Notwithstanding this intention, the University reserves the right to amend or terminate any or all of the plans at any time. The University may amend any term of a plan, including but not limited to benefit design, eligibility, and/or premium cost sharing, and benefits do not vest. Amendments will be made in writing. Amendments may generally be made through an announcement of changes from the Benefits Office or a modification of an insurance policy, without the need for a formal signed plan amendment. In the event of plan termination, plan assets, if any, will be dispositioned by any method permitted by law.

No Guarantee of Employment

Nothing contained in the Plans shall be construed as a contract of employment between the University and any employee, or as a right of any employee to be continued in the employment of the University, or as a limitation of the right of the University to discharge any of its employees, with or without cause.

Overpayments

To the extent permitted by law, if, for any reason, any benefit under any Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a participant or a beneficiary, the participant or the beneficiary shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, the Plan Administrator, or the Employer (or designee) may recover that incorrect payment, whether or not it was made due to the insurance company’s or Plan Administrator’s (or its designee’s) own error, from the person to whom it was made, or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the
sole discretion of the Plan Administrator or the insurance companies. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

**Misrepresentation or Fraud**

To the extent permitted by law, the Plan Administrator and TPA reserve the right to terminate a participant’s benefits, deny future benefits, take legal action against a participant, and/or set off any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan in the case of any participant who obtains benefits wrongfully due to intentional misrepresentation or fraud.

**Non-Discrimination and Accessibility Notice**

Strong Memorial Hospital and the University of Rochester Health Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Strong Memorial Hospital and the University of Rochester Health Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Strong Memorial Hospital and the University of Rochester Health Plans
- Provide free aids and services to people with disabilities to communicate effectively with us, such as
  - qualified sign language interpreters
  - written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as
  - qualified interpreters
  - information written in other languages

If you believe that Strong Memorial Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: SMH Grievance Coordinator, 601 Elmwood Ave Box 612, Rochester, NY 14642, phone: 585-275-0954, fax: 585-756-5584.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For interpreter services, please email Interpreter_services@urmc.rochester.edu.
## How Your Coverage Is Affected

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<th>Health Care and Dental Plans</th>
<th>Flexible Spending Accounts (FSAs)</th>
<th>Health Savings Account (HSA)</th>
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<tr>
<td><strong>If you become disabled (non-work-related illness or injury)</strong> . . .</td>
<td>Coverage continues:  - While you are receiving benefits under the Sick Leave Plan for Short-Term Disability  - While you are receiving benefits under the University of Rochester Long-Term Disability Plan (LTD). You continue to pay your normal share of the premium(s).</td>
<td>Health Care FSA: FSA participation continues while you are receiving payments under the Sick Leave Plan for Short-Term Disability paid through the University of Rochester payroll. Note: FSA participation is terminated as of the effective date that you are approved for LTD benefits. Please refer to the section, “If you terminate or change to an ineligible status.”</td>
</tr>
<tr>
<td><strong>If you are on an unpaid leave or temporary layoff</strong> . . .</td>
<td>Coverage continues unless you sign a form canceling coverage.</td>
<td>FSA participation stops as of the effective date of the unpaid leave or temporary layoff. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 30 days of your return. Health Care FSA: You must elect COBRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during an unpaid leave of absence or temporary layoff. Otherwise, you will have 90 days from the effective date of the unpaid leave or temporary absence to submit eligible expenses incurred prior to the FSA cancellation date.  - FMLA: For the period covered by an unpaid FMLA Leave, or New York Federal Leave you have the option to continue a Health Care FSA. You will need to contact the Benefits Office to set up billing and will need to pay your share of contributions on an after-tax basis.  - Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.</td>
</tr>
<tr>
<td><strong>If you are on an indefinite layoff</strong> . . .</td>
<td>Coverage continues if you have two or more years of service, unless you sign a form canceling coverage. If you have less than two years of service, your Plan coverage is canceled effective on the last day of the pay period in which your indefinite layoff occurs. Please refer to the section, “If you terminate or change to an ineligible status.”</td>
<td>FSA participation stops as of the effective date of the indefinite layoff. If you return to work in a benefit-eligible position and wish to elect an FSA, you must enroll within 30 days of your return. Health Care FSA: You must elect COBRA continuation coverage, and remit after-tax contributions, to submit eligible expenses incurred during layoff. Otherwise, you will have 90 days from the effective date of the indefinite layoff to submit eligible expenses incurred prior to the FSA cancellation date.  - FSA: Since Dependent Care FSAs are established to allow the employee to work, Dependent Care FSAs are suspended during an unpaid FMLA Leave. You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.</td>
</tr>
<tr>
<td><strong>If you are on a military leave</strong> . . .</td>
<td>Your active coverage continues for up to 12 months unless you sign a form canceling coverage. When coverage stops, you will be sent a separate document that explains your rights to continue coverage for an additional 18 months under COBRA. When you return to work at the University, the University Health Care and Dental Plans will not be required to cover injuries or illnesses that are determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of services in the armed forces. Those will be covered by the uniformed service. However, there will be no waiting periods or pre-existing condition limitations upon your return to work.</td>
<td>FSA participation stops as of the effective date of your military leave. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 30 days of your return. Health Care FSA: You may continue coverage for up to 36 months. You will need to contact the Benefits Office to set up billing and will need to pay your share of contributions on an after-tax basis. You will have 90 days from the effective date of your cancellation to submit eligible expenses incurred prior to the FSA cancellation date. You may make a taxable distribution of all or a portion of the funds remaining in your Health Care FSA or you may elect COBRA/USERRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during your military leave. You will need to complete an FSA Qualified Reservation Distribution Form (available from the UR Benefits Office) to request a distribution. The maximum amount available for distribution is the actual amount in the account (i.e., contributions minus reimbursements).  - Dependent Care FSA: You will have until April 30 following end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.</td>
</tr>
<tr>
<td><strong>If you fail to pay premiums or contributions</strong> . . .</td>
<td>Your coverage is canceled effective the last day of the period for which premiums were paid. COBRA is not available.</td>
<td>Your participation terminates effective the last day of the period for which contributions were made. Health Care FSA: COBRA is not available. You will have 90 days from the effective date of the termination to submit eligible expenses incurred prior to the cancellation date.  - Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.</td>
</tr>
</tbody>
</table>
**Health Care and Dental Plans**

Coverage continues as long as you remain an employee (and if your claim extends beyond 6 months, you are receiving LTD benefits). Premiums will be deducted from your paycheck while you are receiving a paycheck from the University of Rochester. Premiums will not be deducted from the checks issued by Gallagher Bassett; however, premiums for that time period will be deducted from your University paycheck upon your return to work unless you enroll in quarterly billing to pay your share of your health and/or dental premiums.

**Flexible Spending Accounts (FSAs)**

FSA participation continues for the first seven days while you are receiving payments under the Workers' Compensation Plan paid through the University of Rochester payroll. When you return to work in a benefit-eligible position, if you wish to elect an FSA, you must enroll within 30 days of your return.

**Health Care FSA**:

- Health Care FSA: After the seven days, you must elect COBRA continuation coverage and remit after-tax contributions to submit eligible expenses incurred during this time period. You will have 90 days from the effective date of your approved Workers’ Compensation claim to submit eligible expenses incurred prior to the FSA cancellation date. If your absence is concurrent with FMLA leave, see page 53 for additional FMLA continuation options.

- Dependent Care FSA: Since Dependent Care FSAs are established to allow the employee to work, Dependent Care FSAs are suspended. You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.

**Health Savings Account (HSA)**

HSA participation continues for the first seven days while you are receiving payments under the Workers’ Compensation Plan paid through the University of Rochester payroll. After the seven days, HSA contributions via payroll deduction will stop as of the effective date of your approved Workers’ Compensation claim. When you return to work in a benefit-eligible position, if you wish to elect an HSA, you must make a new contribution election. You may make your own tax-deductible HSA contributions during leave.

**If you are on Workers’ Compensation**

Coverage continues as long as you remain an employee (and if your claim extends beyond 6 months, you are receiving LTD benefits). Premiums will be deducted from your paycheck while you are receiving a paycheck from the University of Rochester. Premiums will not be deducted from the checks issued by Gallagher Bassett; however, premiums for that time period will be deducted from your University paycheck upon your return to work unless you enroll in quarterly billing to pay your share of your health and/or dental premiums.

**If you terminate or change to an ineligible status**

Your Plan coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage.

Coverage for your dependents ends on the earlier of the date that your coverage ends or the date that your dependent no longer qualifies as an eligible dependent.

**Health Care Plan**:

Coverage continues if you are considered a full-time employee per the Employer Shared Responsibility Mandate of the Patient Protection and Affordable Care Act (PPACA). See the University’s Measurement and Stability Periods Policy on the Benefits Office website for additional information.

If you are not considered a full-time employee per the PPACA, your health coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible.

**Dental Plan**:

Coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage.

Your FSA participations stop as of your termination date or change to an ineligible status. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA.

**Health Care FSA**:

- Health Care FSA: You will have 90 days from your date of termination or change to an ineligible status to submit eligible expenses incurred prior to the FSA cancellation date.

- Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.

**If you change to a Time-as-Reported (TAR) status**

**Health Care Plan**:

Coverage continues if you are considered a full-time employee per the Employer Shared Responsibility Mandate of the Patient Protection and Affordable Care Act (PPACA). See the University’s Measurement and Stability Periods Policy on the Benefits Office website for additional information.

If you are not considered a full-time employee per the PPACA, your health coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible.

**Dental Plan**:

Coverage will be canceled effective on the last day of your current pay period in which you are benefits-eligible. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage.

Your FSA participations stop as of your transfer date. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA.

**Health Care FSA**:

- Health Care FSA: You will have 90 days from your transfer date to submit eligible expenses incurred prior to the FSA cancellation date.

- Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.

**If you retire or otherwise become ineligible for benefits**

Eligibility for coverage continues. If you wish to change or waive health care or dental coverage, you must complete a form to cancel coverage. If you (or a covered dependent) are eligible for Medicare and you wish to continue Health Care Plan coverage, you will need to complete an enrollment form for the Health Care Plans available to Medicare-eligible retirees outlined in the "Medicare-Eligible Retirees Health Program Guide" which is available at [www.rochester.edu/working/hr/benefits/retirement/post-retirement/](http://www.rochester.edu/working/hr/benefits/retirement/post-retirement/).

You will be billed quarterly for your share of the premium.

**Post-Retirement Health and Dental Cost-Sharing**:

The University’s share of the health care and dental premiums varies depending on the Post-Retirement Grandparent Level of the faculty or staff member. To view costs for each plan, visit [www.rochester.edu/benefits](http://www.rochester.edu/benefits). Select Employment Changes and then select Retirement.

Your FSA participation stops on the date of your retirement. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA.

**Health Care FSA**:

- Health Care FSA: You will have 90 days from the date of your retirement to submit eligible expenses incurred prior to the FSA cancellation date.

- Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.

**HSA contributions** via payroll deduction stop as of your date of termination or change to an ineligible status. However, your HSA is solely owned by you and will continue with you even after you are no longer employed by the University or if you otherwise become ineligible for benefits. This means that you can continue to make contributions to your HSA as long as you are enrolled in HSA-eligible coverage, and you will continue to have access to the funds in your HSA. Your HSA will move from the University group to an individual account within the bank, so please contact your TPA for details.

**When you retire**

Eligibility for coverage continues. If you wish to change or waive health care or dental coverage, you must complete a form to cancel coverage. If you (or a covered dependent) are eligible for Medicare and you wish to continue Health Care Plan coverage, you will need to complete an enrollment form for the Health Care Plans available to Medicare-eligible retirees outlined in the "Medicare-Eligible Retirees Health Program Guide" which is available at [www.rochester.edu/working/hr/benefits/retirement/post-retirement/](http://www.rochester.edu/working/hr/benefits/retirement/post-retirement/).

You will be billed quarterly for your share of the premium.

**Post-Retirement Health and Dental Cost-Sharing**:

The University’s share of the health care and dental premiums varies depending on the Post-Retirement Grandparent Level of the faculty or staff member. To view costs for each plan, visit [www.rochester.edu/benefits](http://www.rochester.edu/benefits). Select Employment Changes and then select Retirement.

Your FSA participation stops on the date of your retirement. When coverage stops, you will be sent a separate document that explains your rights under COBRA continuation coverage for the Health Care FSA.

**Health Care FSA**:

- Health Care FSA: You will have 90 days from the date of your retirement to submit eligible expenses incurred prior to the FSA cancellation date.

- Dependent Care FSA: You will have until April 30 following the end of the Plan Year to submit eligible expenses incurred during the Plan Year. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.

**HSA contributions** via payroll deduction stop as of your date of termination or change to an ineligible status. However, your HSA is solely owned by you and will continue with you even after you are no longer employed by the University or if you otherwise become ineligible for benefits. This means that you can continue to make contributions to your HSA as long as you are enrolled in HSA-eligible coverage, and you will continue to have access to the funds in your HSA. Your HSA will move from the University group to an individual account within the bank, so please contact your TPA for details.
### Important Things to Know

#### Health Care and Dental Plans Flexible Spending Accounts (FSAs)

If you die . . .

<table>
<thead>
<tr>
<th>Health Care Plan: (1) And you had more than five years of service and were eligible to retire, your family members’ health coverage will continue at the active cost-sharing for one year if your surviving spouse/domestic partner and/or eligible children are non-Medicare eligible.</th>
<th>Health Care FSA: Any claims incurred prior to your death must be submitted for reimbursement within 90 days. Your family members may elect COBRA on the Health Care FSA and remit after-tax contributions for the remainder of the Plan Year; this will allow them to receive reimbursement for claims they incur after your death.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For those with Post-Retirement Grandparent Level 1, 2, or 3: Your family members’ cost-sharing will be based on your Post-Retirement Grandparent Level.</td>
<td></td>
</tr>
<tr>
<td>• For those with a Post-Retirement Grandparent Level 4 or 5: Your family members’ cost-sharing will be equal to the full premium of the plan they are enrolled in.</td>
<td></td>
</tr>
<tr>
<td>(2) And you had more than five years of service but were not eligible to retire, your family members’ health coverage will continue at the active cost-sharing for one year. After one year, your non-Medicare eligible family members will be offered 36 months of COBRA continuation coverage.</td>
<td>Dependent Care FSA: Your family members will have until April 30 following the end of the Plan Year to submit eligible expenses incurred prior to your death. The amount available for reimbursement is limited to the amount credited to your Dependent Care FSA, less any prior reimbursements.</td>
</tr>
<tr>
<td>(3) And you had fewer than five years of service, your family members will be offered 36 months of COBRA continuation coverage in the health care plan.</td>
<td>Your FSA participation will end as of the date of your death.</td>
</tr>
<tr>
<td>Dental Plan: Your family members will be offered 36 months of COBRA continuation coverage in the Dental Plan (regardless of your length of service or retirement eligibility).</td>
<td></td>
</tr>
</tbody>
</table>

#### Health Savings Account (HSA)

- If your spouse is the primary beneficiary, your spouse will have the option to transfer the balance from your account into a new account in his/her name and continue to use the funds for tax-free, qualified expenses. If your spouse meets the eligibility requirements for the new account, he/she may contribute to the HSA.
- If your primary beneficiary is not your spouse, all funds in your HSA will be distributed to your beneficiary, and your HSA will be closed. Note: The distributed funds will be taxable.
- If you do not have a beneficiary, consult with your legal advisor on how your HSA will be affected.

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1. If you return to work within 30 days, your prior elections will automatically be reinstated upon your return.
2. Only faculty and staff who are enrolled in an HSA-Eligible Plan and satisfy certain other requirements can make contributions to an HSA. If you are enrolled in an HSA-Eligible Plan and eligible to contribute to an HSA, you can contribute directly to your HSA outside of payroll deductions, at any time, as long as you do not exceed your annual maximum. You also can change your HSA election (payroll deductions) anytime throughout the year.
3. Employees and retirees must continue to pay their share of the premium for the Health Care Plan and Dental Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month in which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Employees and retirees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care Plan or Dental Plan coverage until the next Open Enrollment period and until any premiums past due are paid to the University. Employees and retirees returning to work with an outstanding balance will be subject to arrears billing. The employee’s share of the premium is based on their salary, University service and full-time/part-time status prior to the start of the layoff.
4. The University reserves the right to change or terminate plans at any time, including benefits provided to current and future retirees.
5. A separate brochure explains the Health Care Plans available to Medicare-eligible retirees, Medicare-eligible surviving spouses/domestic partners and eligible Medicare-eligible children. This brochure can be viewed at www.rochester.edu/benefits/retirement/post-retirement.
Employee Retirement Income Security Act (ERISA)

As a participant in the Health Care Plans, Dental Plans, and a Health Care FSA, 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 UR Benefits Office and at the University Plan Administrator's office, all Plan documents, 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.
• Obtain, upon written request to the University Plan Administrator, copies of documents governing the administration of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
• Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

For the Health Care Plans only:
• Elimination of exclusionary periods of coverage for preexisting conditions under your group Plan.
• Continue health care coverage, dental coverage, or Health Care FSA coverage for yourself, spouse, or dependents if there is a loss of coverage under a plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary Plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

Prudent Action 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 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, your union, 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 benefit is denied or ignored, in whole or in part, you have a 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. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof regarding the qualified status of a medical child support order, 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 regarding the qualified status of a medical child support order, you may file suit in federal court. If it should happen that 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 UR Benefits Office or the

Important HSA Information
Neither the University’s arrangement for making contributions to the HSAs of employees, nor the HSAs themselves, are ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). This is because the government views HSAs as a variety of personal savings accounts over which you, as the account holder, have sole responsibility for investing and using funds in accordance with IRS requirements for HSAs. In contrast with ERISA plans, in the case of your HSA, the University does little more than remit funds to an account invested and controlled solely by you. This means that you have greater responsibility in establishing and maintaining the HSA. For example, under the HSA arrangement:
• Your contributions to an HSA are completely voluntary,
• The University does not limit your ability to move the HSA’s funds to another HSA,
• The University does not impose conditions on the utilization of HSA funds, and
• The University does not make or influence your HSA investment decisions.

Because you have sole control over your HSA, you are responsible for making sure that your contributions do not exceed permitted limits and that your distributions are properly reported on your federal tax return.
University 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 Benefits 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Although this statement emphasizes your right to bring a lawsuit or to seek Labor Department assistance, it is unlikely that disputes will require such action. The claims review procedure should be able to meet the needs of any employee. In extreme cases, if legal action seems necessary, the University Plan Administrator has been designated as the agent for service of legal process.

*Plan Information*

For the Health Care Plans, the Dental Plans, and the FSAs:

- The University Plan Administrators are:
  
  Associate Vice President of Human Resources  
  University of Rochester  
  (ID No. 16-0743209)  
  Office of Human Resources, Benefits Office  
  44 Celebration Dr.  
  Suite 2300  
  Rochester, NY 14627  

- The Associate Vice President of Human Resources is the agent for legal process in any action involving the University of Rochester Health Care Plans, the Dental Plans, and the FSAs.

- The Plan Year is from January 1–December 31, and the plan numbers are:
  
  - 517: Health Care Plans  
  - 518: Dental Plans  
  - 515: Employee Assistance Program
Terms to Know

Annual Salary—For an hourly paid staff member, annual salary is standard annual hours times the hourly rate of pay; for a salaried faculty or staff member, annual salary is 12 times the regular monthly salary or 24 times the regular semi-monthly salary. For faculty members under the School of Medicine and Dentistry Master Clinical Faculty Compensation Plan, annual salary means “Targeted Salary.”

Appointment—The action which begins a relationship with the University in a specific position, such as member of the faculty; the period during which such a relationship is in effect.

Coinsurance—The percentage of the fee that the Plan pays for certain covered expenses once you have met your deductible.

Continuous Employment—Actively at work in a position eligible for the full range of University Benefit Plans. Absences due to leave of absence or layoff would be included in determining continuous employment.

Copayment or Copay—A fixed dollar amount you must pay to a provider at the time services are received.

Deductible—The amount of out-of-pocket expenses that you must pay for health services before the Plan begins to pay benefits for many covered services.

Full-Time—For hourly staff (excluding those professional, administrative, and supervisory paid hourly): a regular weekly work schedule of at least 35 hours; for all professional, administrative, and supervisory staff: a weekly work schedule of 40 hours or more; for faculty: a normal full teaching and research load as defined for the faculty by the college or school concerned.

Hired—For purposes of determining post-retirement benefits, “hired” is defined as an appointment to a position that is eligible for the full range of University Benefit Plans.

In-Network—Doctors, hospitals, or other health care facilities that are affiliated with the TPA you have selected. When you use a doctor, hospital, or other health care facility that is in-network, your out-of-pocket costs are lower, because these providers have agreed to accepted discounted rates in return for your use of their services and because the benefit coinsurance is higher.

Layoff (indefinite)—An indefinite suspension of University employment because of reduction of staff or elimination of a position for more than four months or for unspecified duration, not over one year.

Layoff (temporary)—A layoff that equates to a temporary suspension of University employment because of reduction of staff or elimination of a position with the expectation of return to work within four months of the day the layoff begins.

Leave of Absence—An approved absence which does not end, but does change the appointment relationship. Leave may be for research or study, to permit a visiting appointment elsewhere, for personal reasons, or for disability.

Negotiated Costs—The amount the network provider has agreed with the Third-Party Administrators (TPAs) to accept as payment.

Out-of-Network—Doctors, hospitals, or other health care facilities that are not affiliated with the TPA you have selected. When you use a doctor, hospital, or other health care facility that does not participate in the network, your out-of-pocket costs are higher, because these providers have not agreed to accept discounted rates and because the benefit coverage is generally lower.

Out-of-Pocket Maximum—The maximum amount you pay each Plan Year to receive covered services after you meet your deductible. Once you meet your out-of-pocket maximum, the Plan pays 100% of covered services you receive. In-network and out-of-network services are subject to separate out-of-pocket maximums.

Part-Time—A regular weekly or monthly schedule which is less than that required for full-time status but not less than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff. For faculty it indicates that the individual carries at least half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

Preferred Provider Organization (PPO)—A Preferred Provider Organization, or PPO, is a health care benefit plan that allows those covered to receive care by network and non-network providers. In many cases those covered will receive a higher level of benefits for using a network provider in addition to the lower fees charged by the provider. The network provider will automatically bill the Plan, and patients are not billed for charges higher than the amount allowed by the TPA.

Reasonable Charges (also referred to as “Reasonable and Customary,” “R&C,” or “Usual, Customary, and Reasonable”)—For services provided by or on behalf of a network physician, the reasonable charge is an amount that does not exceed negotiated costs. For services provided by out-of-network providers, the maximum amount considered under your Plan for payment is reasonable charges. The Third-Party Administrator develops reasonable charges in its discretion, taking into account factors
such as the complexity of the service, the range of services provided, and the prevailing charge level in the geographic area where the provider is located.

**Regular**—A period of appointment in hourly and professional, administrative, and supervisory positions that is expected to exceed four months, unless otherwise defined in collective bargaining agreements; period of appointment for faculty-instructional staff that is at least one year (or one academic year) or, if shorter, is expected to be renewed. Appointments primarily for furthering education (for example, graduate assistant) are not considered “regular” appointments.

**Rehired**—For purposes of determining post-retirement benefits, “rehired” is defined as an appointment to a position that is eligible for the full range of University Benefit Plans from an appointment that was not eligible for the full range of University Benefit Plans or following termination or retirement.

**Retirement**—An ending of appointment (whether voluntary or involuntary) at normal retirement age or beyond after having met the ten-year service requirement, or

- For regular full-time and part-time faculty and staff **hired or rehired prior to 1/1/96** at an earlier age if the individual has reached age 55 and has met the ten-year service requirement. (The ten-year service requirement may be met by cumulative employment at the University or another higher education institution.)
- For regular full-time and part-time faculty and staff **hired or rehired 1/1/96 and thereafter** at an earlier age if the individual has reached age 60 and has met the ten-year service requirement. (The ten-year service requirement may be met by cumulative employment at the University or another higher education institution, as long as there is continuous employment at the University for the immediate five years prior to retirement.)

Once Retired, Post-Retirement Benefits continue to be based on status, age, and years of service at the time of initial Retirement, even if the Retiree returns to work. There is no adjustment to the Grandparent Level, years of service, or age calculation to determine the level of Post-Retirement benefits based upon Post-Retirement Rehire and employment. However, in the event a Retiree returns to work and becomes eligible for Health Care Plan coverage, Dental Plan coverage, and/or University-paid Basic Term Life insurance coverage because the Retiree has satisfied the eligibility criteria for active employees to participate, the Retiree will be limited to the active employee options and will become ineligible for the post-retirement benefit options.

**Retirees**—Retirees (University Retired faculty and staff members)

- Regular full-time and part-time faculty and staff who were **hired or rehired prior to 1/1/96** and who have retired with University consent and (1) who have reached age 55 and (2) who have met the ten-year service requirement. (The ten-year service requirement may be met by cumulative employment at the University or another higher education institution.)
- Regular full-time and part-time faculty and staff who were **hired or rehired 1/1/96 and thereafter** and who have retired with University consent and (1) who have reached age 60, and (2) who have met the ten-year service requirement. (The ten-year service requirement may be met by cumulative employment at the University or another higher education institution, as long as there is continuous employment at the University for the immediate five years prior to retirement.)

**Temporary**—A period of appointment in hourly and professional, administrative, and supervisory positions of not over four months, unless otherwise defined in collective bargaining agreements; period of appointment for faculty-instructional staff of less than one year (or one academic year) and for which renewal is not expected.

**Termination**—An ending of appointment for reason other than retirement.

**Third-Party Administrator (TPA)**—A TPA processes health care claims and provides additional services for members. The University offers the choice of two TPAs to administer its health care plans: Aetna or Excellus BlueCross BlueShield.
Appendices

Appendix A: When You Can Make Benefit Changes Outside of Open Enrollment

You can only enroll in or change your Health Care Plan options and FSA contributions, or add eligible dependents to your Health Care Plans and/or Dental Plan, during the year if you experience a change that is considered a qualifying event. Changes due to a qualifying event must be received within 30 days (within 60 days for loss of Medicaid or CHIP coverage or eligibility for a state’s premium assistance program) of the qualifying event and will not be retroactive, except as noted for the addition of a child due to birth, adoption, or placement for adoption for health plan benefits.

Coverage changes will generally be effective on the date of the qualifying event or the date the completed form is received in the Benefits Office, whichever is later. Where a coverage change is effective mid-way through a payroll period, your employee contribution for that payroll period will be determined based on your coverage election in effect as of the last day of the payroll period. For example, if an employee elected to add coverage mid-way through the payroll period, the employee would be charged the full (not pro-rated) employee contribution for that pay period, even if coverage was in effect for only part of the pay period. Likewise, if an employee elected to drop coverage midway through a payroll period, the employee would not be charged any payroll deduction for that pay period, even though coverage was in effect for part of the payroll period.

In most cases, newly benefit-eligible faculty and staff will have 30 days to enroll for benefits, and their Health Care and Dental Plan elections will be effective the first day of the month following or coinciding with the hire date. Newly benefit-eligible SMH residents and fellows will also have 30 days from their hire or appointment date to complete their benefit election, and their Health Care and Dental Plan enrollments will be effective as of their hire dates or appointment date. However, please note that benefit-eligible employees rehired within 30 days or less after termination, or who return to work within 30 days or less after commencing a leave of absence (except in the case of FMLA or USERRA leave), shall automatically be reinstated in his or her pre-termination (or pre-leave) elections unless another qualifying event permits a change. If an individual terminates employment with an affiliate of the University that does not participate in the Plan (for example, Highland Hospital), and is hired by the University within 30 days or less, then the employee will be able to enroll and make new elections in this Plan due to the change in worksite, but those election changes will be prospective only (i.e., coverage will not be retroactive to the date of hire).

Similar to mid-year coverage changes, where enrollment for new hires is effective mid-way through a payroll period, your employee contribution for that payroll period will be determined based on your coverage election in effect as of the last day of the payroll period. For example, if your new hire coverage become effective mid-way through a payroll period, your employee share of the premiums for that payroll period will be the same as for an employee who had coverage for the entire payroll period.
<table>
<thead>
<tr>
<th>EVENT DESCRIPTION</th>
<th>HEALTH PLAN</th>
<th>DENTAL PLAN (Traditional &amp; Medallion)</th>
<th>HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)</th>
<th>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You get married</strong>…</td>
<td>You may enroll or add coverage for your spouse and any newly eligible dependents. You also may change coverage to another Plan option and/or change your Third-Party Administrator.</td>
<td>You may enroll or add coverage for your spouse and any newly eligible dependents. You also may change coverage to another Plan option.</td>
<td>You may enroll or increase election if become covered under spouse’s plan.</td>
<td>You may enroll or increase election if the marriage lowers dependent care expenses, may drop or decrease election if the marriage lowers expenses, or can be covered under spouse’s plan.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td><strong>Your domestic partner becomes eligible for benefits</strong>…</td>
<td>You may add coverage for your domestic partner and any newly eligible dependent to your current plan option on an after-tax basis if you are already enrolled for coverage.</td>
<td>You may add coverage for your domestic partner and any newly eligible dependents to your current Plan option on an after-tax basis if you are already enrolled for coverage.</td>
<td>You cannot make any changes.</td>
<td>You cannot make any changes.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td><strong>You get divorced or legally separated, or your marriage is annulled</strong>…</td>
<td>You must discontinue coverage for your former spouse and any dependents that become ineligible (e.g., stepchildren), and you may remove any dependents that will be added to your former spouse’s plan.</td>
<td>You must discontinue coverage for your former spouse and any dependents that become ineligible (e.g., stepchildren), and you may remove any dependents that will be added to your former spouse’s plan.</td>
<td>You may enroll or increase election if losing coverage under spouse’s health plan; may drop or decrease election.</td>
<td>You may enroll or increase election if event increases dependent care expenses or triggers eligibility or if you lose coverage under spouse’s Dependent Care FSA, may drop or decrease election if event changes dependent eligibility (e.g., if child now resides with ex-spouse) or lowers dependent care expenses.</td>
<td>Date of event or date form is completed, whichever is later.</td>
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<tr>
<td><strong>You end a domestic partnership</strong>…</td>
<td>You must discontinue coverage for your former domestic partner and any dependents that become ineligible (e.g., stepchildren or partners’ children). You may enroll if you lost coverage under your former domestic partner’s plan. You may add coverage for any eligible dependents that are no longer covered under your former domestic partner’s plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order.</td>
<td>You must discontinue coverage for your former domestic partner and any dependents that become ineligible (e.g., partner’s children). You may enroll if you lost coverage under your former domestic partner’s plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former domestic partner’s plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order.</td>
<td>You may drop or decrease election if becoming a dependent to your current Plan option.</td>
<td>You may enroll or increase election if event increases dependent care expenses as a result of the end of domestic partnership.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td><strong>Your eligible dependent passes away</strong>…</td>
<td>You must drop the deceased from coverage. You may enroll or add coverage for yourself or any eligible surviving dependents that are no longer covered under the deceased’s plan. You also may change coverage to another Plan option and/or change your Third-Party Administrator.</td>
<td>You must drop the deceased from coverage. You may enroll or add coverage for yourself or any eligible dependents that are no longer covered under the deceased’s plan. You also may change coverage to another Plan option.</td>
<td>You may enroll or increase election if you lose coverage under an opposite-sex spouse’s plan.</td>
<td>You may enroll or increase election if event increases dependent care expenses. You may drop or decrease election if event changes dependent eligibility (e.g., if you lose custody of stepchild) or lowers dependent care expenses.</td>
<td>Date of event.</td>
</tr>
<tr>
<td><strong>YOU HAVE THE OPPORTUNITY TO CHANGE YOUR BENEFITS IF . . .</strong></td>
<td><strong>HEALTH PLAN</strong></td>
<td><strong>DENTAL PLAN</strong> (Traditional &amp; Medallion)</td>
<td>**HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)**1, 12</td>
<td><strong>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)1, 12</strong></td>
<td><strong>EFFECTIVE DATE</strong></td>
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<tr>
<td>You have a new child (by birth, adoption, or placement for adoption) . . .</td>
<td>You may enroll or add coverage for your spouse or domestic partner and any newly eligible dependents. If you and/or your eligible dependents gain coverage under a spouse’s or domestic partner’s plan, you may discontinue coverage for yourself and/or any affected dependents.</td>
<td>You may enroll or add coverage for your spouse or domestic partner and any newly eligible dependents. You also may change coverage to another Plan and/or change your Third-Party Administrator. If you and/or your eligible dependents gain coverage under a spouse’s or domestic partner’s plan, you may discontinue coverage for yourself and/or any affected dependents.</td>
<td>You may enroll or increase election if the order requires you to provide coverage.</td>
<td>You may enroll or increase election if event increases dependent care expenses; may drop or decrease election if event changes eligibility or decreases expenses (e.g., if spouse stops working to care for other children in day care).</td>
<td>Health and Dental: Date of birth/adoption/ placement for adoption of the new child. Enrollment or changes with respect to other dependents will be effective the date of event or date form is completed, whichever is later. FSA: Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>Your dependent is no longer eligible for benefits under the University Plan (e.g., child reached the age at which coverage is no longer available) . . .</td>
<td>You must discontinue coverage for your ineligible spouse, domestic partner, or dependent.</td>
<td>You must discontinue coverage for your ineligible spouse, domestic partner, or dependent.</td>
<td>You may drop or decrease election if the spouse, domestic partner, or dependent was an eligible dependent for the Health Care FSA.</td>
<td>You may drop or decrease election if the spouse, domestic partner, or dependent was an eligible dependent for the Dependent Care FSA.</td>
<td>Date of event or date form is completed, whichever is later. (Plan coverage terminates as of the date of ineligibility. Children turning 26 continue coverage through the end of the calendar month.)</td>
</tr>
<tr>
<td>You experience a change in employment status that impacted your eligibility for benefits (e.g., retirement, commencing or returning from a leave of absence in excess of 30 days, termination of employment, transfer to the University from another affiliated employer) . . .</td>
<td>If you have become newly eligible: You may enroll for coverage.</td>
<td>If you have become newly eligible: You may enroll for coverage.</td>
<td>If you have become newly eligible: You may enroll in a Health Care FSA or Dependent Care FSA.</td>
<td>If you have become newly eligible: You may enroll in a Health Care FSA or Dependent Care FSA.</td>
<td>Newly eligible: Date of event or date form is completed, whichever is later. No longer eligible: Refer to previous appropriate column.</td>
</tr>
<tr>
<td>Your eligible dependent experiences a qualifying election change event under his or her own employer’s cafeteria plan (e.g., change in employment status, HIPAA special enrollment right, significant cost increase or curtailment of coverage, etc.) . . .</td>
<td>You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Benefits Office.</td>
<td>You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Benefits Office.</td>
<td>You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Benefits Office.</td>
<td>You may make corresponding changes permitted by Cafeteria Plan tax regulations, as determined by the Benefits Office.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You become enrolled as an adult child under your parent’s employer’s group health Plan during an annual Open Enrollment period, HIPAA special enrollment period, or as a result of your parent experiencing a qualifying election change event under his or her own employer’s Cafeteria Plan . . .</td>
<td>You may discontinue coverage.</td>
<td>No change permitted.</td>
<td>No change permitted.</td>
<td>No change permitted.</td>
<td>Date of event or date form is completed, whichever is later.</td>
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<tr>
<td>You experience a significant change in the cost of dependent care and the cost change is imposed by a dependent care provider who is not your relative . . .</td>
<td>No change permitted.</td>
<td>No change permitted.</td>
<td>No change permitted.</td>
<td>No change permitted.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You or your former spouse is required to provide coverage for a dependent by legal judgment or court order (e.g., Qualified Medical Child Support Order) . . .</td>
<td>You may enroll and add coverage for your eligible dependent if the order requires you to provide coverage. You may drop coverage for the child.</td>
<td>You may enroll and add coverage for your eligible dependent if the order requires you to provide coverage. You also may change coverage to another Plan option and/or change your Third-Party Administrator. If the order requires another individual to provide coverage (e.g., former spouse or child’s other parent), you may drop coverage for the child.</td>
<td>You may enroll or increase election if the order requires you to provide coverage.</td>
<td>You may enroll or increase election if the order requires you to provide coverage.</td>
<td>Date required by court order or date order is determined by Plan Administrator to be qualified, whichever is later.</td>
</tr>
</tbody>
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1. COBRA coverage may be available to you and your eligible dependents.
2. COBRA coverage may be available to another Plan and/or change your Third-Party Administrator.
3. If the order specifies an additional amount.
4. If the order specifies an additional amount.
5. Your ineligible spouse, domestic partner or dependent’s plan.
6. COBRA: Date of event or date form is completed, whichever is later.
<table>
<thead>
<tr>
<th><strong>YOU HAVE THE OPPORTUNITY TO CHANGE YOUR BENEFITS IF . . .</strong></th>
<th><strong>HEALTH PLAN</strong></th>
<th><strong>DENTAL PLAN (Traditional &amp; Medallion)</strong></th>
<th><strong>HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)</strong></th>
<th><strong>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)</strong></th>
<th><strong>EFFECTIVE DATE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Your current or former spouse (or his or her child) who is a tax dependent, or your current domestic partner (or his or her child) who is a tax dependent, or your child changes coverage from another employer’s plan during the other employer’s open enrollment period . . .</td>
<td>You may enroll or add coverage for your affected spouse, domestic partner, and eligible dependents who lose coverage under the other plan. You also may change coverage to another Plan option and/or change your Third-Party Administrator.</td>
<td>You may enroll or add coverage for your affected spouse, domestic partner, and eligible dependents who lose coverage under the other plan. You also may change coverage to another Plan option.</td>
<td>You may not make any changes to your Health Care FSA.</td>
<td>You may increase your contribution amount if your spouse decreases coverage. If your spouse increases coverage, you may decrease your coverage.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>Your current domestic partner (or his or her child) who is not a tax dependent, changes coverage from another employer’s plan during their employer’s open enrollment period that is different than the University’s Open Enrollment period . . .</td>
<td>You may add coverage for your affected domestic partner and eligible dependents on an after-tax basis. You may discontinue coverage for any dependents who were receiving University coverage on an after-tax basis that gain coverage through the other employer’s plan.</td>
<td>You may add coverage for your affected domestic partner and eligible dependents on an after-tax basis. You may discontinue coverage for yourself and any dependents that gain coverage through the other employer’s plan.</td>
<td>No change allowed.</td>
<td>No change allowed</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>Your or your eligible dependents lose eligibility for other employer group health plan coverage, governmental health insurance, or nongovernmental health insurance through no fault of your own, exhaust COBRA coverage, or another employer ceases contributions toward health insurance for you or your eligible dependents . . .</td>
<td>You may enroll for coverage for yourself, your spouse, your domestic partner or your children who were affected. You also may change coverage to another Plan option and/or change your Third-Party Administrator.</td>
<td>You may enroll for coverage yourself, your spouse, your domestic partner or your children who were affected. You also may change coverage to another Plan option.</td>
<td>You may enroll or increase elections to reflect loss of eligibility for other Health Care FSA.</td>
<td>You may enroll or increase election if you or your spouse or tax dependent loses eligibility for other employer’s Dependent Care FSA.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You start or return from an FMLA or military leave . . .</td>
<td>If you start an FMLA or military leave, you may cancel your coverage. Upon returning from an FMLA or military leave, you may reinstate your prior coverage. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.</td>
<td>If you start an FMLA or military leave, you may cancel your coverage. Upon returning from an FMLA or military leave, you may reinstate your prior coverage. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.</td>
<td>If you have a Health Care FSA at the start of an FMLA or military leave, you may cancel your Health Care FSA. If you are returning from an FMLA or military leave and had a Health Care FSA, you may reinstate your prior election amount. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.</td>
<td>If you have a Dependent Care FSA at the start of an FMLA or military leave, you may cancel your Dependent Care FSA. If you must cancel your Dependent Care FSA if your FMLA leave will exceed two weeks (this is not required for military leaves). If you are returning from an FMLA or military leave and had a Dependent Care FSA, you may reinstate your prior election amount. If you have experienced another election change event while on leave or have been on leave in excess of 30 days, you may make an election change in accordance with the rules for that event.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You or your eligible dependents enroll in Medicaid or Medicare . . .</td>
<td>Cancel or reduce coverage for individual who enrolled in Medicaid or Medicare.</td>
<td>Cancel or reduce coverage for individual who enrolled in Medicaid or Medicare.</td>
<td>You may drop or decrease election if the affected individual was an eligible dependent for the Health Care FSA.</td>
<td>No change is permitted.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You or your eligible dependents lose entitlement to Medicaid or a state children’s health insurance program . . .</td>
<td>Enroll or increase coverage for yourself, your spouse, your domestic partner, or your children (whichever lost the entitlement). You also may change coverage to another Plan option and/or change your Third-Party Administrator.</td>
<td>Enroll or increase coverage for yourself, your spouse, your domestic partner, or your children (whichever lost the entitlement).</td>
<td>No change is permitted.</td>
<td>No change is permitted.</td>
<td>Date of event or date form is completed, whichever is later.</td>
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<td>YOU HAVE THE OPPORTUNITY TO CHANGE YOUR BENEFITS IF . . .</td>
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<tr>
<td><strong>HEALTH PLAN</strong></td>
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<td>Enroll or increase coverage for yourself, your spouse, your domestic partner or your children (whomever gained the entitlement). If you lose coverage under your spouse's or former spouse's plan, you may increase or decrease your contribution (if your qualifying event results in a change in your dependent care expenses). Please see page 14 “Choosing a Coverage Option.”</td>
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<td>No change is permitted. No change is permitted. No change is permitted. Date of event or date form is completed, whichever is later.</td>
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<td><strong>DENTAL PLAN</strong> (Traditional &amp; Medallion)</td>
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<td>You may change coverage to another plan or discontinue coverage if you elect coverage through another employer’s plan. Cost Increase: You may change coverage to another plan option or discontinue coverage if you elect coverage through another employer’s plan. Cost Decrease: You may elect new coverage or change coverage to another plan.</td>
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<td>No change is permitted. No change is permitted. No change is permitted. N/A</td>
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<td><strong>HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)</strong></td>
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<td>If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you made to your HSA via payroll deduction will stop on the effective date. If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you made to your HSA via payroll deduction will stop on the effective date.</td>
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<td>No change is permitted. No change is permitted. No change is permitted. Date of event or date form is completed, whichever is later.</td>
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<td><strong>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)</strong></td>
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<tr>
<td>If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you made to your HSA via payroll deduction will stop on the effective date. If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you made to your HSA via payroll deduction will stop on the effective date.</td>
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<td>No change is permitted. No change is permitted. No change is permitted. Date of event or date form is completed, whichever is later.</td>
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1. Any request to change an FSA must be consistent with the qualifying event as noted on pages 12 and 13 (e.g., if you lose a Health Care FSA, you may increase or decrease your contribution if you have a loss of coverage under your spouse’s or former spouse’s plan. If you lose your Health Care FSA, you may increase or decrease your contribution (if your qualifying event results in a change in your dependent care expenses). Please see page 14 “Choosing a Coverage Option.”
2. If you enrolled or disenrolled under the YOUR HSA-Eligible Plan as the result of a qualifying event, you may be eligible to contribute to an HSA. However, the HSA contribution maximums (see page 41) are prorated if you will be covered by the YOUR HSA-Eligible Plan for less than 12 months of the current calendar year. Please see page 14 “Choosing a Coverage Option.”
3. If you experience a significant cost change in the premium for medical coverage . . .
4. If you terminate coverage under the YOUR HSA-Eligible Plan as the result of a qualifying event, any contributions you make to your HSA via payroll deduction will stop on the effective date.
5. When changing due to a qualifying event, the FSA annual election cannot be reduced below the amount of payroll contribution already deduction or claims submitted for the calendar year if it would result in a negative balance, and the change must be consistent with the qualifying event. Please see pages 12 and 13.

This Guide summarizes the University of Rochester’s Health Care Plans, Dental Plans, Lifestyle Management Plan, Employee Assistance Program, and Flexible Spending Accounts effective January 1, 2018. The University reserves the right to modify, amend, or terminate the plans at any time, including actions that may affect coverage, cost-sharing, or covered benefits, as well as benefits that are provided to current and future retirees.
Appendix B: Eligible Dependents for the FSAs and HSA

You can only claim reimbursement from the FSAs for expenses incurred by your qualifying tax dependents. The definition of qualifying dependent for FSAs is different than the definition for purposes of your federal tax return. The following section described the individuals who are eligible dependents for purposes of the FSAs.

For the Health Care FSA, Eligible Dependents Include:
- Your spouse, if your marriage is recognized by federal law.
- Your biological child, stepchild, adopted child, child placed for adoption, or foster child (defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), until December 31 of the year in which he or she turns age 26. In the case of divorced or separated parents, a child is treated as a dependent of both parents.
- Your brother/sister, half-brother/half-sister, stepbrother/stepsister, or descendant of any such sibling (e.g., niece/nephew), or a descendant of your biological child, stepchild, adopted child, child placed for adoption, or foster child (e.g., grandchild).
- Whose residence is your household for more than half of the calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),
- Who is younger than you and is under age 19 (or age 24 if a full-time student) as of the end of the calendar year, or who is permanently and totally disabled regardless of age,
- Who has not provided more than one-half of his or her own support18 that year,
- Who has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year, and
- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children).
- In the case of divorced or separated parents, a child is treated as a dependent of both parents.
- Your relative (child described above or descendant of such child (e.g., grandchild), your sibling described above or descendant of any such sibling (e.g., niece/nephew), your parent, parent’s ancestor (e.g., grandparent), stepparent, aunt/uncle, parent in-law, son/daughter-in-law, brother/sister-in-law,
- Who receives over half of his or her support18 from you for the calendar year,
- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children),
- Who is not anyone else’s Qualifying Child.18
- Someone other than a spouse who has the same principal residence as you for the entire calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),
- Who is a member of your household for the entire calendar year (the relationship must not violate local law),
- Who receives over half of his or her support18 from you for the calendar year,
- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children),
- Who cannot be claimed as anyone else’s Qualifying Child on their federal tax return.

For the Dependent Care FSA, Eligible Dependents Include:
- Your spouse if your marriage is recognized by federal law,
- Whose residence is your household for more than half of the calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),
- Who is physically or mentally incapable of caring for himself or herself,
- Your biological child, stepchild, adopted child, child placed for adoption, or foster child (defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or a descendant of any such child, your brother/sister, half-brother/half-sister, stepbrother/stepsister, or descendant of any such sibling (e.g., niece/nephew),
- Whose residence is your household for more than half of the calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),
- Who is under age 13,
- Who has not provided more than one-half of his or her own support18 that year,
- Who is a member of your household for the entire calendar year (the relationship must not violate local law),
- Who receives over half of his or her support18 from you for the calendar year,
- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children),
- Who cannot be claimed as anyone else’s Qualifying Child on their federal tax return.

Other Eligible Expenses
While over-the-counter medications are not considered eligible expenses under the Health Care FSA or HSA without a prescription, insulin is an exception. Insulin, along with some over-the-counter supplies (such as bandages and contact lens solution) will still be considered eligible expenses without a prescription.

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18 The Third-Party Administrator cannot be changed as a result of a qualifying event.
Eligible Dependents for Purposes of HSA Reimbursements

- Your spouse, if your marriage is recognized by federal law.

- Your biological child, stepchild, adopted child, child placed for adoption, or foster child (defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction), or a descendant of any such child, your brother/sister, half-brother/half-sister, stepbrother/stepsister, or descendent of any such sibling (e.g., niece/nephew),

- Whose residence is your household for more than half of the calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),

- Who is younger than you and is under age 19 (or age 24 if a full time student) as of the end of the calendar year, or who is permanently and totally disabled regardless of age,

- Who has not provided more than one-half of his or her own support from you for the calendar year,

- Who has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year, and

- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children).

- In the case of divorced or separated parents, a child is treated as a dependent of both parents.

- Your relative (child described above or descendent of such child (e.g., grandchild), your sibling described above or descendent of any such sibling (e.g., niece/nephew), your parent, parent's ancestor (e.g., grandparent), stepparent, aunt/uncle, parent in-law, son/daughter-in-law, brother/sister-in-law, or someone other than a spouse who is a member of your household for the entire calendar year (and the relationship must not violate local law);

- Whose residence is your household for more than half of the calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),

- Who receives over half of his or her support from you for the calendar year,

- Who is a citizen or resident of the United States or resident of Canada or Mexico (there is an exception for adopted children),

- Who is not anyone else's Qualifying Child.

- Someone other than a spouse who has the same residence as you for the entire calendar year (temporary absences due to special circumstances, e.g., illness, education, business, vacation, or military service, are disregarded),

- Who is a member of your household for the entire calendar year (and the relationship must not violate local law),

- Who receives over half of his or her support from you for the calendar year,

- Who is a citizen or resident of the U.S., or resident of Canada or Mexico (there is an exception for adopted children),

- Who cannot be claimed as anyone else's Qualifying Child on their federal tax return.

20 To determine whether you provide more than half of the total support for your relative or other person sharing your residence, you must compare the amount of support you provide with the amount of support the individual receives from all sources, including Social Security, welfare payments, the support you provide, and the support the individual provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for the individual, you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information). Please note that an individual could qualify as a tax dependent for purposes of the health benefits, but not on your tax return, if that individual earns more than the exemption amount as defined in Code Section 151(d) ($4,000 for 2015), but still receives more than half of his or her support from you.

**Note:** This is not the same definition as applies to determine whether an individual is eligible to contribute to their own HSA. This is only the definition that applies when determining whether you can submit expenses to your HSA on behalf of your dependent.
Appendix C: Diabetic Supplies and Equipment

The following diabetics supplies and equipment are covered under the University’s Health Care Plans as Durable Medical Equipment (DME):

- Alternate site blood glucose monitors (must meet criteria to be covered)
- Blood glucose monitors, including all commercially available blood glucose monitors designed for patient use for people diagnosed with diabetes (e.g., monitors with adaptive devices for diabetics who are legally blind, defined as best corrected vision of 20/200); Exception: Lasette laser blood glucose monitor
- Disposable blood glucose monitor
- Needles and syringes for insulin administration
- Insulin pens
- Blood glucose test strips
- Continuous glucose monitoring devices (must meet criteria to be covered)
- Urine test tablets/strips, lancets, and lancing devices
- Control solutions and alcohol swabs
- Glucagon emergency kits or injectable glucagon, defined as prescription items
- Glucose agents
- Insulin, including all commercially available insulin preparations (e.g., insulin analog preparations available in either vial or cartridge)
- Insulin infusion pumps (must meet criteria to be covered), including external insulin infusion devices and supplies such as:
  - Adhesive supplies
  - Batteries
  - Cartridges
  - Infusion sets
  - Skin preparations
  - Other disposable supplies needed to maintain insulin infusion pump therapy, including durable and disposable devices used to assist in the injection of insulin
- Jet injectors (must meet criteria to be covered)
- Oral agents for controlling blood sugar level (prescription oral agents)
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin such as:
  - Syringe magnifiers
  - Non-visual insulin measurement aids (click wheel type of measurement guide using clicking sounds)
- Devices that allow a person to load a syringe by touch alone
- Needle guide
- Syringe vial holders
- Visual reading and urine testing strips, including visual reading and urine testing strips for ketones or urine test strips for both glucose and ketone. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
Appendix D: Claims and Appeals Procedures

Eligibility Claims Procedures
Any participant (employee) or beneficiary (dependent), or an authorized representative acting on behalf of a participant or beneficiary, may assert a claim for eligibility. Throughout this section, any of these individuals are referred to generically as a “Claimant.”

The following procedures shall apply if a Claimant is inquiring about eligibility to participate in a Program. These rules do not apply if a Claimant is also claiming the right to receive benefits under a Program rather than just inquiring about eligibility. If a Claimant is also filing a claim for benefits, the Claimant shall use the Benefits Claims Procedures that apply to the particular Program under which the claim is being brought, as described in the following section.

A. Determination of Benefits
A claim for eligibility must be submitted to the University of Rochester Benefits Office (the “Benefits Office”) in writing. The Benefits Office will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Benefits Office determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Benefits Office will notify the Claimant, 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 Benefits Office expects to render a decision.

B. Notification of Adverse Claim Determination
If the claim is denied in whole or in part, the Claimant will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the denial;
- References to the specific plan provisions upon which the benefit determination is based;
- A description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary; and
- A description of the Plan’s appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA (if applicable) if the claim continues to be denied on review.

C. Appeal of Adverse Claim Determination
If the claim for eligibility is denied by the Benefits Office, the Claimant may submit a written appeal to the Manager of the Benefits Office (the “Manager”) requesting a review of the decision. The written appeal must be submitted within 60 days of the Claimant receiving the initial adverse decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Benefits Office’s decision. The Claimant 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, the Claimant may have reasonable access and copies of all Plan documents, records, and other information relevant to the claim.

The Manager will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension, and set forth the date the Manager will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal
If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions upon which the determination was based;
- A statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to the Claimant’s benefit claim upon request; and
- A statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor and the right to bring a civil legal action under ERISA (if applicable).

Benefits Claims Procedures
All claims for benefits under a particular benefit Program described in this booklet should be submitted in accordance with the terms of that Program as described in the benefits booklets or other materials from the Third-Party Administrator (TPA) and will be subject to the claims review procedure for that Program. However, if the particular issue on which a claim is based does not relate to any Program, or if the Program materials lack a claims procedure that satisfies any then-applicable ERISA claims procedure requirements, the relevant claims procedures below shall apply or shall supplement the defective claims procedures to bring them into compliance. Where a Program’s materials with a defective claims procedure specify that claims can be filed or must be responded to in a time period more generous to the Claimant than the procedures below, then these procedures shall also be read to require the more generous time period for submission or response.

The Claims Reviewer is the individual or entity assigned to review claims or appeals for a Program. Where a Program’s materials specify that claims be sent to an insurer or TPA, then the insurer or TPA shall be the Claims Reviewer for purposes of the procedures that follow. Where a Program’s materials do not contain any claims procedure, then the following procedures shall apply.

The applicable Claims Reviewers for the Programs described in this booklet are listed below:
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<thead>
<tr>
<th>Benefit</th>
<th>Claims Reviewer</th>
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<tr>
<td>Health Plan (including vision benefits)</td>
<td>Aetna</td>
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<tr>
<td>(if Aetna is the health care TPA)</td>
<td>1-877-864-4583</td>
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<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>The denial notice will include the address</td>
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<td>where the appeal can be sent.</td>
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<tr>
<td>Health Plan (including vision benefits)</td>
<td>Excellus BlueCross BlueShield</td>
</tr>
<tr>
<td>(if Excellus BlueCross BlueShield is the health care TPA)</td>
<td>165 Court Street, Rochester, NY 14647</td>
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<tr>
<td></td>
<td>1-800-659-2808 or (585) 232-2632</td>
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<td></td>
<td><a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a></td>
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<td>The denial notice will include the address</td>
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<td>where the appeal can be sent.</td>
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<tr>
<td>Health Plan (for Postdocs)</td>
<td>Aetna</td>
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<td></td>
<td>Non-HMO Claims and Member Services (OAMC)</td>
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<tr>
<td></td>
<td>P.O. Box 14089 Lexington, KY 40512</td>
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<td></td>
<td>Phone: 877-204-9186</td>
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<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Vision1 Plan (for Postdocs)</td>
<td>Aetna</td>
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<td></td>
<td>Vision Preferred</td>
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<td></td>
<td>P.O. Box 8504 Mason, OH 45040</td>
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<td></td>
<td>1-877-9-SEE-AETNA (1-877-973-3238)</td>
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<td><a href="http://www.aetnavision.com">www.aetnavision.com</a></td>
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<td>VSP Supplemental Vision Plan</td>
<td>VSP</td>
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<td>800-877-7195</td>
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<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td>Dental Plan</td>
<td>Excellus BlueCross BlueShield</td>
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<td></td>
<td>165 Court Street, Rochester, NY 14647</td>
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<td></td>
<td>1-800-724-1675</td>
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<td></td>
<td><a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a></td>
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<td><a href="http://www.rochester.edu/benefits/dental">www.rochester.edu/benefits/dental</a></td>
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<td>The denial notice will include the address</td>
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<td>where the appeal can be sent.</td>
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<tr>
<td>Dental Plan (for Postdocs)</td>
<td>MetLife</td>
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<td></td>
<td>1-800-ASK-4MET</td>
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<td></td>
<td><a href="http://www.metlife.com/dental">www.metlife.com/dental</a></td>
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<td>P.O. Box 981282, El Paso, TX 79998-1282</td>
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<tr>
<td>Prescription Drug Plan</td>
<td>Excellus BlueCross BlueShield</td>
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<tr>
<td>(if Excellus BlueCross BlueShield is the health care TPA)</td>
<td>165 Court Street, Rochester, NY 14647</td>
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<td>1-800-499-2838</td>
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<td><a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a></td>
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<td>The denial notice will include the address</td>
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<td>where the appeal can be sent.</td>
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<tr>
<td>Prescription Drug Plan</td>
<td>Aetna</td>
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<tr>
<td>(if Aetna is the prescription drug TPA)</td>
<td>1-888-792-3862</td>
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<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>The denial notice will include the address</td>
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<td>where the appeal can be sent.</td>
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<tr>
<td>Prescription Drug Plan</td>
<td>Garnett-Powers &amp; Associates</td>
</tr>
<tr>
<td>(for Postdocs)</td>
<td>1-844-243-0027</td>
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<td></td>
<td><a href="http://www.garnett-powers.com/rochester">www.garnett-powers.com/rochester</a></td>
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<tr>
<td>Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA</td>
<td>Aetna FSA</td>
</tr>
<tr>
<td>(if Aetna is the health care TPA)</td>
<td>P.O. Box 4000, Richmond, KY 40476-4000</td>
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<tr>
<td></td>
<td>Fax: 1-888-238-3539</td>
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<td><a href="http://www.rochester.edu/benefits/fsa">www.rochester.edu/benefits/fsa</a>.</td>
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<td>Claims forms are available from the UR</td>
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<td>Benefits Office, or can be printed from</td>
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<td><a href="http://www.rochester.edu/benefits/fsa">www.rochester.edu/benefits/fsa</a>.</td>
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<td></td>
<td>Claims can be faxed directly to 1-888-AETFLEX (238-3539).</td>
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<tr>
<td>Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA</td>
<td>Lifetime Benefits Solutions, Inc.</td>
</tr>
<tr>
<td>(if Excellus BlueCross BlueShield is the health care TPA or the</td>
<td>Claims Dept.</td>
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<td>participant does not have University health care)</td>
<td>P.O. Box 2330, Blasdell, NY 14219</td>
</tr>
<tr>
<td></td>
<td>Fax: 1-877-256-7228</td>
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<td></td>
<td><a href="http://www.lifetimebenefitsolutions.com">www.lifetimebenefitsolutions.com</a></td>
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<td>After submitting claims online, all receipts</td>
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<td>and supporting documentation must be faxed</td>
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<td>to Lifetime Benefits Solutions, Inc. at 1-877-256-7228.</td>
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<tr>
<td>Lifestyle Management Program, Condition Management Program, EAP, or</td>
<td>UR Benefits Office</td>
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<tr>
<td>any other claims related to Group Health Plan benefits described in</td>
<td>44 Celebration Dr. Suite 2300, Rochester,</td>
</tr>
<tr>
<td>this booklet</td>
<td>NY 14627</td>
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<tr>
<td></td>
<td>(585) 275-2084; Fax: (585) 273-1054</td>
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<tr>
<td></td>
<td><a href="mailto:benefitsofice@hr.rochester.edu">benefitsofice@hr.rochester.edu</a>; <a href="http://www.rochester.edu/benefits">www.rochester.edu/benefits</a></td>
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<td>Requests for benefits should be made by</td>
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<td>contacting the appropriate administrator</td>
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<td>listed on page 5.</td>
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<td>Claimants who are dissatisfied with the</td>
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<td>administrator's response may file a formal</td>
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<td>claim with the Benefits Office. The Manager</td>
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<td>of the Benefits Office will review all</td>
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<td>appeals.</td>
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This procedure applies only to claims submitted for Group Health Plan benefits under a Program. In addition, it applies to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals for Group Health Plan benefits will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives, or other similar matters regarding any individual or organization making decisions in the claims and appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

Certain aspects of the claims procedures apply only to Plans that are not grandfathered medical plans under 26 CFR § 54.9815-1251T and that are subject to the expanded claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA). Those sections are indicated throughout the procedures that follow. In cases where the Department of Labor has indicated that there is a delayed enforcement deadline for a particular PPACA requirement described in this section, the Plan Administrator or Claims Reviewer may delay implementation of the particular delayed provision until the enforcement deadline.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The University health care plans are non-grandfathered and subject to the expanded claims procedures. The Health Care FSA, Limited Purpose FSA, EAP, and Dental Plans are not subject to the expanded claims procedures.

The following terms are defined for purposes of this subsection:

- **Post-Service Claim** means any claim for a benefit which is not a Pre-Service Claim as defined below. Most Health Care FSA and Limited Purpose Health Care FSA claims are considered Post-Service Claims.
- **Pre-Service Claim** means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care (e.g., if the plan requires precertification in order for a service to be covered).
- **Urgent Care Claim** means a claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  - Could seriously jeopardize the Claimant’s life or health or the ability of the Claimant to regain maximum function, or
  - In the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant’s medical condition determines that the claim involves Urgent Care.

- **Group Health Plan or plan** means, for purposes of this claims procedure, any Program described in the Health Program Guide that is a group health plan as defined by ERISA, which generally means that the Program provides benefits for health care or treatment.
- **Claims Reviewer** means the person or entity responsible for the relevant claims determination under the Plan.
- **Appeals Unit** means the group or individuals employed by the Claims Reviewer assigned to review appeals of adverse benefit determinations.
- **Non-Grandfathered Health Plans** means the Health Plan, Prescription Drug Plan, and Condition Management Program.
I. Internal Review

A. Determination of Benefits

A claim for Health Plan, Dental Plan, or Prescription Drug Plan benefits is generally submitted by the Claimant's health care provider. Health Care FSA claims are submitted automatically by the Claimant's health care provider if the Claimant is enrolled in a University Health Plan and has not opted out of Automatic Claims Transfer. Out-of-network claims for Health Plan, Dental Plan, or Prescription Drug Plan benefits and Health Care FSA or Limited Purpose Health Care FSA claims may be submitted manually by the Claimant in writing. The amount of time that the Claims Reviewer has to respond to a claim for benefits will depend upon the type of claim for benefits being made, as provided below.

- Post-Service Claims: The Claims Reviewer will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim but not later than 30 days after the claim is received. This period may be extended for up to 15 days, provided that the Claims Reviewer both determines that an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Claims Reviewer expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's time frame for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Claims Reviewer.

- Pre-Service Claims: The Claims Reviewer will notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the claim. This period may be extended for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Claims Reviewer expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's time frame for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Claims Reviewer. In the event the Claimant fails to follow proper plan procedures in submitting a claim, the Plan will be notified within 24 hours after the Claims Reviewer initially receives the claim so that the Claimant can make proper adjustments.

- Concurrent Care Decisions: In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated. If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided...
that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant, within the relevant time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the denial;
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and, if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- The contact information for the Employee Benefits Security Administration, and/or any applicable office of health insurance consumer assistance, or ombudsman established under the Public Health Service Act (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- Identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; and
- The denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and
- In the case of an adverse determination involving Urgent Care, a description of the expedited review process available to such claims.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth above shall follow within three days.

C. Appeal of Adverse Claim Determination

If the claim is denied in whole or in part, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records, and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all plan documents, records, and information relevant to the claim free of charge. In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his or her claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Claims Reviewer's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Appeals Unit of the Claims Reviewer. The Appeals Unit will not have been involved in the initial benefit determination nor will the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment,
the Claims Reviewer will consult a health care professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the health care professional who was consulted in the initial adverse benefit determination. If a health care professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

After an appeal is filed, the Claims Reviewer will respond to the claim within a certain period of time. The amount of time that the Claims Reviewer has to respond is based on the underlying claim for benefits as set forth below:

- Post-Service Claims: within a reasonable period, but no more than 60 days after receiving Claimant's appeal request.
- Pre-Service Claims: within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving Claimant's appeal request.
- Urgent Care Claims: as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving Claimant's appeal request.

D. Interim Notification of New Evidence or Rationale During Pendency of Interim Appeal
In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, if during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

E. Notification of Final Internal Decision on Appeal
If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the denial;
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- References to the specific Plan provisions on which the benefit determination was based;
- A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- A description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
- If the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.
- If the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- Identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- A statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

II. Standard External Review
This Section II.A. describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described in Section III.A., below).

A. Requests for External Review.
A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. Except for requests for external review initiated before September 20, 2011, external review is only available for:

- A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
- An adverse benefit determination (including a final adverse benefit determi-
nation) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan’s determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
- Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan’s standard for medical necessity or appropriateness);
- Whether treatment involved “emergency care” or “urgent care,” affecting coverage or the level of coinsurance;
- A determination that a medical condition is a preexisting condition;
- The Plan’s general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
- Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan’s wellness program, if any;
- The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
- Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

### B. Preliminary Review.

Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant’s failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
- The Claimant has exhausted the Plan’s internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and
- The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48-hour period after the receipt of notification.

### C. Referral to Independent Review Organization.

The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally recognized accrediting organization to conduct the external review. The Claims Reviewer will contract for assignments under the Plan with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- The IRO will timely notify the Claimant in writing of the request’s eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.
- Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider
its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - The Claimant's medical records;
  - The attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;
  - The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
  - Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and
  - The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

- The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;
  - A statement that judicial review may be available to the Claimant; and
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

D. Reversal of Plan's Decision.
Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

III. Expedited External Review
A. Request for Expedited External Review.
When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or
- A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or
health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

B. Preliminary Review.
Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in Section II above for Standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section II for Standard External Review to the Claimant of its eligibility determination.

C. Referral to Independent Review Organization.
Upon determination that a request is eligible for expedited external review following preliminary review described in Section II above, the Claims Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in Section II above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expedient method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process.

D. Notice of Final External Review Decision.
The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of Section II above for Standard External Review, except that the notice will be provided as expeditiously as the Claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.

E. Reversal of Plan’s Decision.
Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

F. IRO Recordkeeping Requirements
After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Dependent Care FSA Claims Procedures
The following procedures apply for benefit claims under the Dependent Care FSA Program.

A. Determination of Benefits
A claim for benefits under the Dependent Care FSA must be submitted to the Claims Reviewer in writing on forms specified by the Claims Reviewer. The Claims Reviewer will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Claims Reviewer determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Claims Reviewer will notify the Claimant, 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 Claims Reviewer expects to render a decision.

B. Notification of Adverse Claim Determination
If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant, within the time period described above, with a written notice of the denial. The notice will include:
- The specific reason(s) for the denial;
- References to the specific plan provision upon which the benefit determination is based;
- A description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary; and
- A description of the plan’s appeals procedures and applicable time limits.

C. Appeal of Adverse Claim Determination
If the claim is denied in whole or in part, the Claimant may submit a written appeal to the Claims Reviewer requesting a review of the decision. The written appeal must be submitted within 60 days of the Claimant receiving the initial adverse decision. The appeal should clearly state the reason or reasons why the Claimant disagrees with the decision. The Claimant 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, the Claimant may have reasonable access and copies of all plan documents, records, and other information relevant to the claim.
The Claims Reviewer will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Claims Reviewer will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal
If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will include:

- The specific reason(s) for the adverse determination; and
- References to the specific plan provisions on which the determination was based.

Voluntary Appeal Procedures
To the extent the plan’s or a Program’s claims procedures include a voluntary level of appeal, the plan:

- Waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan or Program;
- Agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;
- Declares that a Claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the mandatory appeals permitted by ERISA claims regulations;
- Shall provide to any Claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant’s rights to any other benefits under the plan or Program and information about the applicable rules, the Claimant’s right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and
- Shall not impose any fees or costs on the claimant as part of the voluntary level of appeal.

Statute of Limitations and Exhaustion of Administrative Remedies
The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, Claims Reviewer, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in the United States District Court for the Western District of New York, to review the Claims Reviewer’s decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer’s decision on appeal. Civil actions cannot be brought in any other federal or state court.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. De minimis;
2. Not likely to cause, prejudice or harm to the Claimant;
3. Attributable to good cause or matters beyond the Plan’s control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan’s receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan’s basis for asserting that it meets the above exception that includes a specific description of its basis, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant’s request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed 10 days). Time periods for re-filing the claim shall begin to run upon Claimant’s receipt of such notice.