



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [www.rochester.edu/benefits](http://www.rochester.edu/benefits) or by calling **585-275-2084**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call **585-275-2084** to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Accountable Health Partners (AHP): Employee (EE) Only \$500; EE+ Family (FAM) \$1,250. In Network: EE Only \$1,000; EE+ FAM \$2,500. Out-of-Network (OON): EE Only \$2,000; EE+ FAM \$6,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. In-network office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	*Salary < \$52,000; AHP: EE Only \$2,000; FAM \$4,000. In Network: EE Only \$3,000; FAM \$5,500. OON: EE Only \$5,000; FAM \$10,000. Salary > \$52,000; AHP: EE Only \$2,500; FAM \$5,000. In Network: EE Only \$3,500; FAM \$7,000. OON: EE Only \$5,000; FAM	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. *NOTE: the <\$52,000 salary band includes residents and fellows and the >\$52,000 includes all part-time (PT) employees.
<b>What is not included in the out-of-pocket limit?</b>	\$10,000. <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://ahpnetwork.com">ahpnetwork.com</a> (AHP), <a href="http://aetna.com">aetna.com</a> (Aetna) or <a href="http://excellusbcb.com">excellusbcb.com</a> (Excellus) or call (585)758-7823 (AHP), 1-877-864-4583 (Aetna) or 1-800-659-2808 (Excellus) for a list of in-network providers.	If you use an in-network doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>network</u> provider might use an out-of-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$65 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	None
	Preventive care / screening / immunization	No charge	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.aetnapharmacy.com/premierplus">www.aetnapharmacy.com/premierplus</a> or <a href="http://www.excellusbcb.com">www.excellusbcb.com</a>	Generic drugs	Not applicable	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 (retail), \$37.50 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Not applicable	20% coinsurance with minimum (min) & maximum (max)/prescription, <u>deductible</u> doesn't apply: \$25 min & \$60 max (retail), \$62.50 min & \$150 max (mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
	Non-preferred brand drugs	Not applicable	35% <u>coinsurance</u> with min & max/prescription, <u>deductible</u> doesn't apply: \$50 min & \$120 max (retail), \$125 min & \$300 max (mail order)	Not covered	
	<u>Specialty drugs</u>	Not applicable	Applicable cost as noted above for generic or brand drugs	Not covered	Limit one retail supply at a network pharmacy. All other fills must be made at a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	10% <u>coinsurance</u> ambulatory surgery center; 25% <u>coinsurance</u> all other facilities	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalties apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Other outpatient services: 10% <u>coinsurance</u>	Office: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	Outpatient services provided by Behavioral Health Partners (BHP) covered at 100% (no deductible or copay)
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Penalties apply for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal/Postnatal Office visits	No charge	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). <u>Penalties</u> may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Penalties</u> apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$65 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	45 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. <u>Age</u> and <u>frequency</u> limits may apply to <u>Habilitation services</u> .
	<u>Habilitation services</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$65 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	120 days/calendar year. <u>Penalties</u> apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Penalties</u> apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	\$35 <u>copay</u> /visit	\$65 <u>copay</u> /visit	40% <u>coinsurance</u>	1 routine eye exam/calendar year.
	Children's glasses	95% <u>coinsurance</u> after \$60 allowance	95% <u>coinsurance</u> after \$60 allowance	95% <u>coinsurance</u> after \$60 allowance	None.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

## Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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|--|---|--|
| <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs (other than services through lifestyle and condition management programs)</li></ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"><li>• Acupuncture - 10 visits/calendar year.</li><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids - \$600 maximum/3 years per child up to age 19.</li><li>• Infertility treatment - For more information about limitations &amp; exceptions, see policy document.</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine eye care (Adult) - 1 routine eye exam/calendar year.</li></ul> |
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## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact your respective Third Party Administrator: Aetna 1-888-982-3862 or Excellus 1-800-499-1275.
- You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your respective Third Party Administrator: Aetna 1-888-982-3862 [www.aetna.com](http://www.aetna.com) or Excellus 1-800-499-1275 [www.excellusbcbcs.com/UR](http://www.excellusbcbcs.com/UR).
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html> (Aetna) or [excellusbcbcs.com/UR](http://excellusbcbcs.com/UR) (Excellus).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan Meet Minimum Value Standard? Yes.**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862 Aetna or 1-800-499-1275 for Excellus.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

**Peg is Having a baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** \$500
- **Specialist copayment** \$35
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$80
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,840</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$500
- **Specialist copayment** \$35
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$500
- **Specialist copayment** \$35
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$780</b>

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.