For Medicare-Eligible Retirees

Health Program

Guide

2016 Edition
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The University of Rochester is committed to providing you and your family with comprehensive health care benefits in retirement. This Health Program Guide highlights the benefits and services available to you as a Medicare-eligible retiree. The “2016 Health Care Plans At-a-Glance for Medicare-Eligible Retirees” shows a side-by-side comparison of the Health Care Plans. We encourage you to take the time to understand the different plan options available to you, so you can select the plan that is cost-effective and appropriate for your needs—and those of your family.

Outlined in this Guide are the health care and dental program options available during the January 1 through December 31, 2016 plan year.

**CREDITABLE PRESCRIPTION DRUG COVERAGE**

If you or your covered dependents are eligible for Medicare, it’s important for you to know that the plan prescription drug coverage provides Creditable Coverage—coverage that, overall, is at least as good as the Medicare Part D standard plan—if you elect the Preferred Gold HMO-POS with University Major Medical or the University Complementary Care Plan with Major Medical (the GoldAnywhere PPO, Preferred Gold Standard HMO-POS and USA Care PPO plan options include Part D coverage). If you opt out of medical coverage, you will not have Creditable Coverage with the University in 2016. The Creditable Coverage Notice is available by contacting the Benefits Office at 1-585-275-2084 or online at [www.rochester.edu/benefits](http://www.rochester.edu/benefits).
## HEALTH PROGRAM RESOURCES

<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact...</th>
</tr>
</thead>
</table>
| **GoldAnywhere PPO**          | MVP Health Care  
220 Alexander St., Rochester, NY 14607  
1-800-665-7924  
(TTY 1-800-662-1220)  
www.mvphealthcare.com |
| **Preferred Gold Standard HMO-POS** | MVP Health Care  
220 Alexander St., Rochester, NY 14607  
1-800-665-7924  
(TTY 1-800-662-1220)  
www.mvphealthcare.com |
| **Preferred Gold HMO-POS with University Major Medical** | MVP Health Care  
220 Alexander St., Rochester, NY 14607  
1-800-665-7924 (TTY 1-800-662-1220) • www.mvphealthcare.com |
| For University Major Medical, depending on which Third-Party Administrator (TPA) you choose: | Aetna  
P.O. Box 981106, El Paso, TX 79998-1106  
1-877-864-4583 • www.aetna.com  
Aetna Pharmacy Management and Aetna Rx Home Delivery Customer Service:  
1-888-792-3862  
Excellus BlueCross BlueShield  
165 Court St., Rochester, NY 14647  
1-800-659-2808 or 1-585-232-2632 • www.excellusbcbs.com  
Excellus BlueCross BlueShield  
Pharmacy Help Desk: 1-877-391-9296  
Walgreens Mail Order Customer Service: 1-877-501-0096 |
| **University Complementary Care Plan with Major Medical** | Depending on which TPA you choose:  
Aetna  
P.O. Box 981106, El Paso, TX 79998-1106  
1-877-864-4583 • www.aetna.com  
Aetna Pharmacy Management and Aetna Rx Home Delivery Customer Service  
1-888-792-3862  
Excellus BlueCross BlueShield  
165 Court St., Rochester, NY 14647  
1-800-659-2808 or 1-585-232-2632 • www.excellusbcbs.com  
Excellus BlueCross BlueShield  
Pharmacy Help Desk: 1-877-391-9296  
Walgreens Mail Order Customer Service: 1-877-501-0096 |
| **USA Care PPO**              | MVP Health Care  
220 Alexander St., Rochester, NY 14607  
1-800-665-7924 (TTY 1-800-662-1220)  
www.mvphealthcare.com/usacare |
| **Dental Plans**              | Excellus BlueCross BlueShield  
165 Court St., Rochester, NY 14647  
1-800-724-1675 • www.excellusbcbs.com  
www.rochester.edu/benefits/dental |
| **General Benefits**          | UR Benefits Office  
1-585-275-2084; Facsimile 1-585-273-1054  
benefitoffice@hr.rochester.edu  
www.rochester.edu/benefits |
| **Medicare**                  | 1-800-MEDICARE (1-800-633-4227)  
(TTY 1-877-486-2048)  
www.medicare.gov |
Your Guide to Making Enrollment Decisions

Choose and Use Benefits Wisely
You make choices each day that are unique to you, your 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 service 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 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 below for your Health Program benefits.

<table>
<thead>
<tr>
<th>Benefits Available To You</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Options</strong></td>
<td>(Please see page 4 for additional eligibility requirements.)</td>
</tr>
<tr>
<td>• GoldAnywhere PPO (with MVP Part D Prescription Drug)</td>
<td>• Available if you do not live outside the New York State and Vermont service area, excluding these New York counties: Nassau and Suffolk for more than six continuous months</td>
</tr>
<tr>
<td>• Preferred Gold Standard HMO-POS (with MVP Part D Prescription Drug)</td>
<td>• Available if you do not live outside the 16-county service area for more than six continuous months (the service area is described on page 9)</td>
</tr>
<tr>
<td>• Preferred Gold HMO-POS with University Major Medical (prescription drug coverage under Major Medical)</td>
<td>• Available if you do not live outside the 16-county service area for more than six continuous months (the service area is described on page 9)</td>
</tr>
<tr>
<td>• University Complementary Care Plan with Major Medical (prescription drug coverage under Major Medical)</td>
<td>• No residency requirement</td>
</tr>
<tr>
<td>• USA Care PPO (with MVP Part D Prescription Drug)</td>
<td>• Available if you do not live outside the United States or Puerto Rico</td>
</tr>
</tbody>
</table>

| Dental Options*                                               | No residency requirement                                                                |
| • Traditional Dental Assistance Plan                          |                                                                                         |
| • Medallion Dental Plan                                       |                                                                                         |

*Note: You may elect to waive your health care plan coverage but still enroll in dental plan coverage, or waive dental plan coverage and enroll in health care plan coverage. If you elect to waive coverage for any benefits option, you must wait until the next Open Enrollment period or until you experience a Qualifying Event to enroll for coverage. See Appendix A for information on when you can make benefit changes outside of Open Enrollment.

*Staff members who were members of 1199 SEIU prior to retirement are not eligible to enroll for dental plan benefits, in accordance with collective bargaining agreements.
Who Is Eligible for Benefits

The health care and dental coverage plans described in this brochure are available to University of Rochester Medicare-eligible retirees, and their Medicare-eligible spouses/domestic partners, and Medicare-eligible dependents.

Benefits for spouses/domestic partners, who are not eligible for Medicare, and eligible dependent children are addressed in a separate brochure titled *University of Rochester Health Program Guide*, which is available from the Benefits Office or can be viewed online at www.rochester.edu/benefits/health.

Surviving Dependents

Medicare-eligible surviving dependents (widows, widowers, and eligible dependents) of deceased University retirees are eligible to continue coverage under a University Health Care Plan outlined in this Guide.

Medicare-eligible surviving dependents of deceased active regular full-time and part-time faculty/staff members who had met the age and service requirements to retire, but were not retired at the time of their death, also are eligible to continue coverage with the University by enrolling under one of the Health Care Plans outlined in this Guide.

In addition, Medicare-eligible surviving dependents (widows, widowers, and eligible dependents) of a deceased active regular full-time or part-time faculty/staff member, who had five or more years of service but had not met the criteria to retire at the time of death, remain eligible to continue coverage with the University by enrolling under a University Health Care Plan outlined in this Guide for a period of one year following the active regular full-time or part-time faculty/staff member’s death.* (Please note that the plans outlined in this Guide either supplement or coordinate with Medicare. If the surviving dependent elected not to enroll in Medicare, then they would need to contact the Social Security Administration at 1-800-772-1213 regarding enrolling in Medicare.)

*Following one year of coverage through the University under one of the Health Care Plans for Medicare-eligible retirees, depending on the plan you are enrolled in, you may elect continuation coverage (COBRA) for up to 36 months. You can continue coverage in a Medicare Advantage plan without electing COBRA because Medicare Advantage plans are provided through individual insurance policies. (Please refer to pages 34-38 for additional information on COBRA continuation coverage.)
Health care plan cost-sharing for surviving dependents is determined by the Post-Retirement Grandparent Level. For those with Post-Retirement Level of 1R, 2R, or 3R, cost-sharing is based on the Post-Retirement Grandparent Level of the deceased retiree. Surviving dependents of retirees with a 4R or 5R Post-Retirement Grandparent Level pay the full premium for the plan.

Dental coverage ends upon the death of the retiree. Widows/widowers and eligible surviving dependents will be offered 36 months of COBRA continuation coverage in the dental plan. (Please refer to pages 34-38 for additional information on COBRA coverage and requirements.)

Benefits for surviving dependents who are not eligible for Medicare coverage are described in a separate brochure titled *University of Rochester Health Program Guide*, which is available from the Benefits Office or can be viewed online at www.rochester.edu/benefits/health. (Note: Medicare-eligible dependents of active regular full-time and part-time faculty/staff members, who lost active employee group health plan coverage as the result of the death of an employee, also may be eligible to elect COBRA coverage for that plan coverage. However, since there is an option available through the University, COBRA continuation coverage may not be an attractive option or beneficial in each situation because of cost sharing and Medicare Special Enrollment Period requirements.)
Retirees Who Were Members of 1199 SEIU

Individuals who were represented by collective bargaining agreements receive benefits in accordance with those agreements. Staff members who were members of 1199 SEIU prior to retirement are eligible for health care plan benefits, but are not eligible for dental plan benefits, in accordance with those agreements. Copies of those agreements are available upon written request.

Dependents eligible to be covered under your health care plan and/or dental 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
- Your children through the end of the month in which they turn age 26, regardless of 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

*A retiree's domestic partner can have the same or opposite gender as the retiree; provided that the retiree and his/her domestic partner 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 anyone else under 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 a previous 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 partner 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.
A retiree who wants to enroll his or her domestic partner in the University’s benefit plans must have a domestic partner agreement that legally binds a retiree and his or her domestic partner to joint responsibility for their common welfare and financial obligations. Executing and filing a Statement of Domestic Partnership with the City Clerk of City of Rochester will satisfy this requirement. The Benefits Office has the right to request you to produce a copy of this agreement and/or other information that indicates joint financial responsibility, such as joint bank accounts or joint liability on mortgages or other debts, etc. The retiree must also sign and file with the Benefits Office the University’s Certification of Domestic Partner Status. The Certification covers all eligible domestic partner benefits (i.e., the University’s health care, dental care, life insurance, long-term care and tuition assistance programs).

If your domestic partnership ends, then the University must be notified within 60 days of the terminated relationship. You satisfy this requirement by filing a Statement of Termination of Domestic Partnership with the Benefits Office.

Please note: You will be taxed on the value of your domestic partner’s and/or your domestic partner’s children’s health/dental coverage if they do not qualify as your federal tax dependents. You should complete the Affidavit of Domestic Partner’s (Opposite-Sex and Same-Sex) Federal Tax Dependent Status for University Health Benefit Plans if your domestic partner and/or his/her dependent children qualify as your tax dependents under federal tax law. The University encourages you to get advice from a tax professional regarding whether your domestic partner and/or his/her children are your tax dependents before you complete this affidavit.

All required forms are available at the Benefits Office or online at www.rochester.edu/benefits/forms.

**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 Benefits Office if there is a change in eligibility status for any of your dependents covered under the plan.
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 (Part A and Part 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.

Retirees and Covered Dependents Becoming Eligible for Medicare

Retirees and eligible dependents who are not eligible for Medicare coverage are eligible for the YOUR PPO Plan or YOUR HSA-Eligible Plan until they become eligible for Medicare. A separate brochure explains the Health Care Plans available to retirees and eligible dependents that are not eligible for Medicare coverage. This brochure, titled *University of Rochester Health Program Guide*, is available from the Benefits Office and can be viewed online at www.rochester.edu/benefits/health.

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 the non-Medicare-eligible 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 Health Care 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 Rochester Medicare-Eligible Retiree Health Care Plans, then you will not have coverage as a retiree of the University of Rochester. (Benefits for retirees and surviving spouses/domestic partners and eligible children, who are not eligible for Medicare coverage, are described in a separate brochure titled *University of Rochester Health Program Guide*, which is available from the Benefits Office or can be viewed online at www.rochester.edu/benefits/health.)

Please refer to this Guide for information on your right to elect COBRA continuation coverage for an active employee group health plan at the time you lost that plan coverage due to the end of employment (retirement). (Please note that because you have subsidized retiree coverage available to you through the University, COBRA continuation coverage may not be an attractive option for you and may not be beneficial in your situation.)

* Medicare-eligible surviving dependents of deceased active regular full-time and part-time faculty/staff members who had met the age and service requirements to retire, but were not retired at the time of their death, will have coverage canceled on the non-Medicare-eligible plans effective when Medicare Part A and Part B begin or the end of the Special Enrollment period, whichever is earlier.
### Additional Eligibility Requirements for Medicare Advantage Plans

<table>
<thead>
<tr>
<th>Health Care Plan</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GoldAnywhere PPO</strong> (with MVP Part D Prescription Drug)</td>
<td>In addition to being eligible for Medicare, you must also meet the conditions listed below to join GoldAnywhere PPO:</td>
</tr>
<tr>
<td></td>
<td>• You do not live outside the New York State and Vermont service area, excluding these New York counties: Nassau and Suffolk, more than six continuous months.</td>
</tr>
<tr>
<td></td>
<td>• You are enrolled in Medicare Parts A and B.</td>
</tr>
<tr>
<td></td>
<td>• You do not have end-stage renal (kidney) disease.</td>
</tr>
<tr>
<td><strong>Preferred Gold HMO-POS with University Major Medical</strong></td>
<td>In addition to being eligible for Medicare, you must also meet the conditions listed below to join Preferred Gold HMO-POS:</td>
</tr>
<tr>
<td></td>
<td>• You do not live outside the 16-county service area for more than six continuous months. The service area is Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates counties in New York State.</td>
</tr>
<tr>
<td></td>
<td>• You are enrolled in Medicare Parts A and B.</td>
</tr>
<tr>
<td></td>
<td>• You do not have end-stage renal (kidney) disease.</td>
</tr>
<tr>
<td><strong>Preferred Gold Standard HMO-POS</strong> (with MVP Part D Prescription Drug)</td>
<td>In addition to being eligible for Medicare, you must also meet the conditions listed below to join Preferred Gold Standard HMO-POS:</td>
</tr>
<tr>
<td></td>
<td>• You do not live outside the 16-county service area for more than six continuous months. The service area is Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates counties in New York State.</td>
</tr>
<tr>
<td></td>
<td>• You are enrolled in Medicare Parts A and B.</td>
</tr>
<tr>
<td></td>
<td>• You do not have end-stage renal (kidney) disease.</td>
</tr>
<tr>
<td><strong>USA Care PPO</strong> (with MVP Part D Prescription Drug)</td>
<td>In addition to being eligible for Medicare, you must also meet the conditions listed below to join USA Care PPO:</td>
</tr>
<tr>
<td></td>
<td>• You do not live outside the United States or Puerto Rico.</td>
</tr>
<tr>
<td></td>
<td>• You are enrolled in Medicare Parts A and B.</td>
</tr>
<tr>
<td></td>
<td>• You do not have end-stage renal (kidney) disease.</td>
</tr>
</tbody>
</table>

The Centers for Medicare & Medicaid Services (CMS) does not allow a member to be enrolled in more than one Medicare plan. If you are enrolled in GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS or USA Care PPO, and subsequently enroll in another Part D plan or Medicare Advantage plan outside of the University of Rochester Health Care Plans, CMS regulations may require your enrollment in the University of Rochester Plans identified above to be canceled.
How to Enroll

If you decide that you want to make a change in your coverage, you need to submit a completed enrollment form(s) to the Benefits Office, 44 Celebration Drive, Suite 2300, PO Box 270453, Rochester, NY 14627. You will need to complete two enrollment forms if you wish to change your own and your spouse’s/domestic partner’s health care plan coverage.

Your enrollment form must be received:

- By the end of the Open Enrollment period*
- Within 30 days of a Qualifying Event (60 days for Medicaid or CHIP eligibility events).* Appendix A provides additional information on Qualifying Events.

* Enrollment applications for the Medicare Advantage plans (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. If you are moving from a Medicare Advantage plan to the University Complementary Care Plan with Major Medical, in addition to the enrollment form(s), you also must complete the Medicare Advantage disenrollment form(s) prior to the effective date of disenrollment.
Changing Your Benefits

Annual Open Enrollment is the primary time you can enroll or make changes to your health care and dental plan benefits. If you do not make coverage changes during the annual open enrollment period, health care and dental plan elections will continue. Outside of Open Enrollment, you can only enroll in or change your health care plan options and dental plan options, 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, and if the change is permitted by Medicare (if you are enrolled in or would like to enroll in a Medicare Advantage plan).

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/domestic partner, or annulment)
- Change in number of dependents (birth, adoption, placement for adoption, or death)
- Change in your spouse/domestic partner or dependent’s employment status
- Dependent satisfying (or ceasing to satisfy) eligibility requirements for coverage (reach the age at which coverage is no longer available, etc.)
- Change in residence for you, your spouse/domestic partner or dependent outside of the GoldAnywhere PPO, Preferred Gold Standard HMO-POS, or Preferred Gold HMO-POS service area

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.** The qualified change in status must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse/domestic partner 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.

- **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.

HOW TO CHANGE YOUR COVERAGE

If you need to change your coverage because of a Qualifying Event, you will need to complete a Qualifying Event Change form(s) and return the completed form(s) to the University of Rochester Benefits Office within 30 days of the Qualifying Event (or within 60 days for Medicaid or CHIP eligibility events). **Enrollment applications for the Medicare Advantage plans (GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO) must be completed prior to the effective date of medical coverage.** Medicare coverage changes due to birth, adoption, or placement for adoption will be effective on the date of the 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
- Loss of Medicaid entitlement by you, your spouse/domestic partner, 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**

You can request (within 30 days) to enroll in the plan or enroll your eligible dependents if:

- You or your eligible dependents lose other group health plan coverage (or if your employer or your eligible dependent’s employer stops contributing toward your or your dependents’ other coverage),
- You or your eligible dependents exhaust COBRA coverage,
- You marry, or
- You gain a new dependent because of birth, adoption or placement for adoption.

You can request (within 60 days) to enroll in the plan or enroll your family members if you or your family member:

- Loses Medicaid or CHIP coverage because you are no longer eligible, or
- Becomes eligible for a state's premium assistance program under Medicaid or CHIP.

Please note that Medicare has additional rules that govern your ability to change plan options. If you are enrolled or would like to enroll in a Medicare Advantage plan, you can only change options if the change is also permitted by Medicare. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) for more information.
Health Care Plan Options for Medicare-Eligible Retirees

You can find a summary of the plans in the “2016 Health Care Plans At-a-Glance for Medicare-Eligible Retirees” chart which shows a side-by-side comparison of the Health Care Plans. The comparison is available from the Benefits Office or online at www.rochester.edu/benefits/retirement/post-retirement.

Additional information regarding coverage, including the Evidence of Coverage (contract) for the Medicare Advantage plans (GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO) is available by contacting MVP Health Care.

Additional information regarding coverage for the University Complementary Care Plan with Major Medical and the University Major Medical Plan is available by contacting the Benefits Office at 1-585-275-2084.

The University of Rochester offers the following five plans:

**GoldAnywhere PPO (with MVP Part D Prescription Drug)**

GoldAnywhere PPO is a Medicare Advantage Preferred Provider Organization plan that allows you to receive health care from a licensed physician or medical facility of your choice (some services require prior authorization or approval). You have lower out-of-pocket costs when you see in-network providers. Medicare Part D prescription drug coverage is included automatically.

MVP Health Care processes all claims and provides all services for members in the GoldAnywhere PPO plan.

Members will receive a health club membership at participating SilverSneakers locations and $100 in Health Dollars to use toward health and fitness programs.

**Preferred Gold Standard HMO-POS (with MVP Part D Prescription Drug)**

Preferred Gold Standard HMO-POS is a Medicare Advantage Health Maintenance Organization (HMO) that offers care through a network of participating providers. With this plan, you must choose a Primary Care Physician (PCP) to coordinate health care services. A woman may choose a gynecologist along with her PCP. The Point-of-Service (POS/out-of-network) benefit that comes with this plan covers medically necessary services you get from non-plan providers within the United States. The POS benefit for routine care out-of-network covered services is 30% coinsurance with a limit of $5,000 per calendar year. Not all services are covered under the POS Benefit. Additional information regarding out-of-network coverage is explained in the Evidence of Coverage (contract) or by contacting MVP Health Care. Urgent and emergent care is always treated as in-network care. Medicare Part D prescription drug coverage is included automatically.

MVP Health Care processes all claims and provides all services for members in the Preferred Gold Standard HMO-POS portion of the plan.

Members will receive a health club membership at participating SilverSneakers locations and $100 in Health Dollars to use toward health and fitness programs.
**Preferred Gold HMO-POS with University Major Medical**

Preferred Gold HMO-POS is a Medicare Advantage Health Maintenance Organization (HMO) that offers care through a network of participating providers. With this plan, you must choose a Primary Care Physician (PCP) to coordinate health care services. A woman may choose a gynecologist along with her PCP. The Point-of-Service (POS/out-of-network) benefit that comes with this plan covers medically necessary services you get from non-plan providers within the United States. The POS benefit for routine care out-of-network covered services is 30% coinsurance with a limit of $5,000 per calendar year. Not all services are covered under the POS Benefit. Additional information regarding out-of-network coverage is explained in the Evidence of Coverage (contract) or by contacting MVP Health Care. Urgent and emergent care is always treated as in-network care. The University Major Medical portion of this plan covers prescription drugs.

MVP Health Care processes all claims and provides all services for members in the Preferred Gold HMO-POS portion of the plan.

You choose between Aetna or Excellus BlueCross BlueShield as a Third-Party Administrator (TPA) to administer the University Complementary Care Plan with Major Medical.

Members will receive a health club membership at participating SilverSneakers locations and $100 in Health Dollars to use toward health and fitness programs.

**University Complementary Care Plan with Major Medical**

This plan allows you to receive health care from a licensed physician or medical facility of your choice. It coordinates with Medicare Part A and Part B. Services are paid through Medicare first. This plan may cover certain medical services that Medicare does not. The plan covers most hospital and surgical costs that are in excess of Medicare benefits. You choose between Aetna or Excellus BlueCross BlueShield as a TPA to administer the University Complementary Care Plan with Major Medical.

If you enroll in this plan and Medicare Part D, Medicare Part D will be the primary payer for your prescription drug benefits, with the University Health Care Plan as secondary payer.

**UNIVERSITY HEALTH CARE PLAN**

Coverage is considered Creditable Coverage for Medicare Part D. The Creditable Coverage Notice is available by contacting the Benefits Office at 1-585-275-2084 or online at www.rochester.edu/benefits.
USA Care PPO (with MVP Part D Prescription Drug)
USA Care PPO is a Medicare Advantage Preferred Provider Organization plan that allows you to receive health care from a licensed physician or medical facility of your choice as long as that provider is eligible to be paid under Medicare rules and agrees to accept USA Care’s Terms and Conditions of payment. You may wish to contact your provider(s) to ensure they participate with Medicare. Your provider can review USA Care’s Terms and Conditions online at www.mvphealthcare.com/usacare. Medicare Part D prescription drug coverage is included automatically.

MVP Health Care processes all claims and provides all services for members in the USA Care PPO Plan.

Members will receive a health club membership at participating Silver Sneakers locations, and $100 in Health Dollars to use toward health and fitness programs.

Wrap-Around Major Medical Plan (bundled with USA Care PPO, GoldAnywhere PPO, or Preferred Gold Standard HMO-POS)
To obtain a claim form, contact the University of Rochester Benefits Office.

WHAT IS MEDICARE PART D?
Medicare Part D is the prescription drug coverage portion of Medicare. Enrollment in Part D is voluntary. Part D coverage is included with the following plans: GoldAnywhere PPO, Preferred Gold Standard HMO-POS, and USA Care PPO. Note: The prescription drug coverage under the University Major Medical is considered Creditable Coverage.
Prescription Benefit Coverage for the Preferred Gold HMO-POS with University Major Medical or University Complementary Care Plan with Major Medical

**Prescription Drugs**

You elect Aetna or Excellus BlueCross BlueShield as your Third-Party Administrator (TPA) providing prescription drug benefit coverage. You have access to your TPA’s nationwide participating pharmacy network, including national chains and most independent pharmacies. You just need to show your medical/prescription drug ID card at any participating pharmacy to identify yourself as having prescription drug coverage. Retail prescriptions can be filled through any retail pharmacy; however, you may save money by using your TPA’s participating network pharmacy.

Aetna  
www.aetnanavigator.com  
Aetna Pharmacy Management  
Customer Service:  
1-888-792-3862

Excellus BlueCross BlueShield  
www.excellusbcbs.com/ur  
Excellus BCBS Pharmacy Help Desk:  
1-877-391-9296

**Mail Order**

Aetna’s mail order pharmacy, Aetna Rx Home Delivery, or Excellus BlueCross BlueShield’s pharmacy partner, Walgreens, provides mail order services for maintenance medications.

When first utilizing this service, you must obtain a new prescription from your doctor for your first fill written out for up to a 90-day supply and mail in the TPA’s mail order form along with the prescription. Thereafter, you may go online to order refills or check your order status.

Aetna  
www.aetnanavigator.com  
Aetna Rx Home Delivery Customer Service:  
1-888-792-3862

Excellus BCBS – Walgreens  
www.walgreenshealth.com  
Walgreens Customer Care Center:  
1-877-501-0096
## Prescription Drugs

<table>
<thead>
<tr>
<th><strong>URMC Employee Pharmacy Discount</strong></th>
<th>Receive a discount on the usual out-of-pocket cost of your prescriptions prior to reaching your deductible, and then a 25% reduction in cost-sharing once your deductible has been met.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To look up the URMC Employee Pharmacy in Aetna’s DocFind, visit <a href="http://www.aetnanavigator.com">www.aetnanavigator.com</a>. To look up the URMC Employee Pharmacy in the Excellus BlueCross BlueShield Pharmacy Locator tool, visit <a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a> and go to “URMC Employee Pharmacy.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Generic Trial Program</strong></th>
<th>The Generic Trial Program offers a free trial of selected generic medications for the first six months of your prescription. After your deductible is met, the first time you fill a prescription for one of the selected generic medications included in the program, your 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 coinsurance amount.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How it works:</td>
</tr>
<tr>
<td></td>
<td>▪ Your deductible must be met before the Generic Trial Program will apply.</td>
</tr>
<tr>
<td></td>
<td>▪ Ask your health care provider to write you a prescription for one of the generic medications included in the program.</td>
</tr>
<tr>
<td></td>
<td>▪ You will be permitted one free six-month trial per medication.</td>
</tr>
<tr>
<td></td>
<td>▪ 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 coinsurance amount.</td>
</tr>
<tr>
<td></td>
<td>To learn more about the Generic Trial Program, or for a listing of the medications selected for the program, visit Aetna’s website at <a href="http://www.aetnanavigator.com">www.aetnanavigator.com</a> or contact the Aetna Pharmacy Management Customer Service at 1-888-792-3862, or visit Excellus’ website at <a href="http://www.bcbs.com/ur">www.bcbs.com/ur</a> or contact the Excellus Pharmacy Help Desk at 1-877-391-9296.</td>
</tr>
</tbody>
</table>
## Prescription Drugs

### Specialty Medications

Specialty medications must be filled at a designated Specialty Drug Pharmacy. Your TPA has partnered with the URMC Employee Pharmacy as the preferred Specialty Drug Pharmacy for the University’s Health Care Plans. Although not the preferred provider, Aetna’s Specialty Pharmacy and Excellus’ Accredo or Walgreens Pharmacy are also designated specialty pharmacies. However, if you use the URMC Employee Pharmacy for your specialty drug needs, you can take advantage of the discounts available, including a discount on the usual out-of-pocket cost of your specialty medication prior to reaching your deductible, then a 25% reduction in cost-sharing once your deductible has been met.

For specialty medication refills from the URMC Employee Pharmacy, call 1-855-340-4767. For specialty medication refills from Aetna Specialty Pharmacy, call 1-866-782-2779. For specialty medication refills from Excellus’ Accredo Pharmacy, call 1-866-413-4137 or Walgreens Pharmacy, call 1-866-435-2170.

### 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 your TPA 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 your TPA 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 Aetna’s website at www.aetnanavigator.com or contact the Aetna Pharmacy Management Customer Service at 1-888-792-3862, or visit Excellus’ website at www.excellusbcbs.com/ur or contact the Excellus Pharmacy Help Desk at 1-877-391-9296.
Prescription Drugs

Other Online Services

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
- 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

Claims History

- View and print your claims history and obtain a Prescriptions Report which includes prescription number, medication, physician and pharmacy location.

These online services are available to you through your TPA’s website (Aetna: www.aetnanavigator.com or Excellus: www.excellusbcbs.com/ur).
Health Care Plan ID Cards

Once enrolled, you will receive a Health Care Plan ID card that will identify the University Health Care Plan that you have elected.

- **GoldAnywhere PPO**: You will receive one card from MVP Health Care.

- **Preferred Gold Standard HMO-POS**: You will receive one card from MVP Health Care.

- **Preferred Gold HMO-POS with University Major Medical**: If you choose Excellus BlueCross BlueShield as TPA, you will receive two cards (MVP Preferred Gold HMO-POS card and Excellus University Major Medical/Pharmacy card). If you choose Aetna as TPA, you will receive two cards (MVP Preferred Gold HMO-POS card and Aetna University Major Medical/Pharmacy card).

- **University Complementary Care Plan with Major Medical**: If you choose Excellus BlueCross BlueShield as TPA, you will receive one card (Excellus University Complementary Care Medical/Pharmacy card). If you choose Aetna as TPA, you will receive one card (Aetna University Complementary Care Medical/Pharmacy card).

- **USA Care PPO**: You will receive one card from MVP Health Care.

What the Plans Cost You

Retirees’ share of the premium costs varies 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 Health Care Plans Premium Sheet and Dental Plans Premium Sheet for each Grandparent Level. The Benefits Office can provide you with the Health Care Plans Premium Sheet and Dental Plans Premium Sheet that applies to you based on your Post-Retirement Grandparent Level. The premium sheets also are available online at www.rochester.edu/benefits/retirement/post-retirement.

The premium sheets will reflect your share of the premium for the coverage 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 coverage 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 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 enrolled in GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS or USA Care PPO will have coverage terminated in accordance with CMS regulations. 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 premiums past due are paid to the University.
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. (Note: Staff members who were members of 1199 SEIU prior to retirement are eligible for health care plan benefits, but are not eligible to enroll for dental plan benefits, in accordance with collective bargaining agreements.) The Dental Plans are administered by Excellus BlueCross BlueShield.

You have a choice of the:
- Traditional Dental Assistance Plan
- Medallion Dental Plan

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 BlueShield. More than 600 area dentists currently participate with Excellus BlueCross BlueShield. To view a list of participating dentists, go to www.excellusbcbs.com/ur and click on the “Find a Dentist” link under the “Your Dental Plan” section in the lower right corner.

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 Benefits Office or Excellus BlueCross BlueShield. Claim forms are also available at www.rochester.edu/benefits/dental, or call Excellus BlueCross BlueShield at 1-800-724-1675 to request a print copy free of charge.

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 (beginning on page 25), 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 share in the cost of the total premium for dental coverage based on your Post-Retirement Grandparent Level.

To view costs for each plan, visit www.rochester.edu/benefits/retirement/post-retirement.
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.

### Dental Plan Highlights

<table>
<thead>
<tr>
<th>Details</th>
<th>Traditional Dental Assistance Plan</th>
<th>Medallion Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost of Coverage</strong></td>
<td>You pay a premium based on Post-Retirement Grandparent Level.</td>
<td>$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.)</td>
</tr>
<tr>
<td><strong>Maximum Benefit per Calendar Year (per Participant)</strong></td>
<td>$1,000</td>
<td>$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.)</td>
</tr>
<tr>
<td><strong>Benefit Deductible</strong></td>
<td>$50 Single; $150 Family</td>
<td>$50 Single; $150 Family</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100% of in-network negotiated rates, no deductible (Out-of-network claims are subject to balance billing.)</td>
<td>Plan pays 100% of in-network negotiated rates, no deductible (Out-of-network claims are subject to balance billing.)</td>
</tr>
<tr>
<td>(Class I)</td>
<td>(includes cleaning and exams, sealants, bitewing X-rays, space maintainers, fluoride treatments covered up to age 16, emergency palliative treatment and dental prophylaxis)</td>
<td></td>
</tr>
<tr>
<td><strong>Basic Restorative Services</strong></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 II and IIA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Class II</strong></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>(includes fillings and simple extraction oral surgery)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Individual deductibles are embedded within the family deductible.
### Dental Plan Highlights

<table>
<thead>
<tr>
<th>Details</th>
<th>Traditional Dental Assistance Plan</th>
<th>Medallion Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class IIA</strong>&lt;br&gt;(includes oral surgery, endodontics, periodontal surgery, periodontal scaling and root planning, and periodontal maintenance following surgery)&lt;br&gt;</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><strong>Major Restorative Services</strong>&lt;br&gt;(Class III)&lt;br&gt;(includes fixed prosthetics, removable prosthetics, inlays/onlays/crowns, refines/rebases, implants)&lt;br&gt;</td>
<td>Plan pays 15% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Orthodontia</strong>&lt;br&gt;(Class IV)&lt;br&gt;(includes orthodontia—only available for eligible dependents under age 19)&lt;br&gt;</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>
<tr>
<td><strong>Predetermination of Benefits</strong>&lt;br&gt;</td>
<td>Yes (Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment.)</td>
<td>Yes (Excellus BlueCross BlueShield reserves the right to pay for a less expensive treatment.)</td>
</tr>
</tbody>
</table>
Schedule of Covered Dental Services and Supplies

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 and minor procedures,
- Fluoride treatment—twice a calendar year, allowed to age 16,
- Space maintainers—once every five years, allowed to age 16, and
- Sealants—once in 36 months for permanent unrestored molars allowed to age 16.

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

CLASS IIA

- Oral surgery*
- 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
- Implants (limited coverage requires preauthorization)**
- Prosthodontics

*The University Health Care Plan will provide coverage for certain medical treatments. Refer to your SPD for more information.**Benefits for replacement of multiple missing teeth and/or bilaterally missing teeth are allowed as a partial denture.
Benefits are subject to the following provisions 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. 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.

### 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—one 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
• 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.

*Not covered under the Traditional Dental Assistance Plan.*

**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,
• Replacement of teeth removed before coverage is effective including replacement of congenitally missing teeth,
• 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,
• Oral hygiene instructions, plaque/tobacco control programs, and/or dietary instructions,
• Grafting and/or splinting procedures including related procedures, and
• Services not listed under Covered Dental Services and Supplies.

All covered services are subject to the benefit terms specified under your selected dental plan option, the Traditional Dental Assistance Plan or the Medallion Dental Plan.

**Important Information to Know for Medicare Advantage Plans**

GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO are Medicare Advantage Plans. The Evidence of Coverage (contract) and the appeals and grievance procedures are available by contacting MVP Health Care directly. The Evidence of Coverage is the legal detailed description of benefits. It also explains your rights and rules you need to follow when using your coverage for medical care and prescription drugs. (Please refer to page 2 for contact information.)
Important Information to Know for University Complementary Care Plan with Major Medical and University Major Medical

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 Coordination of Benefits (COB) provision.

The intent of COB is to determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Allowable expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

These guidelines determine which plan pays benefits first:

- The plan without a COB provision always pays first.
- The plan covering a person other than as a dependent pays first before the plan covering a person as a dependent.
- The plan covering a person as an active employee (neither laid-off or retired), or as a dependent of an active employee, pays first before the plan covering a person as a laid-off or retired employee or a dependent of such person (but if the other plan does not have such a provision, and as a result each plan determines its benefits after the other, then this paragraph shall not apply).
- 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 covering a person under a right of continuation under COBRA or state law pays after the plan covering a person other than under a right of continuation.
- If none of the above applies, the plan covering the person for the longest time pays first.
Utilization Review
Plan benefits are generally paid only where health services are medically necessary. Aetna and/or Excellus BlueCross BlueShield review proposed and rendered health services to determine whether the services are or were medically necessary. Registered nurses and the Medical Directors of Aetna and/or Excellus BlueCross BlueShield conduct reviews. Plans may not compensate or provide financial incentives to employees or reviewers for determining that services are or were not medically necessary. For more information, contact Aetna and/or Excellus BlueCross BlueShield.

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 copy of the QMCSO are received by the Benefits Office. Participants and beneficiaries can obtain a copy of the University of Rochester QMCSO procedures, without charge, from the 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 TPA’s 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 1-585-275-2084 or the insurer or TPA listed on page 2.

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 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 procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at 1-585-275-2084 or the insurer or TPA listed on page 2.
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. Please refer to the “2016 Health Care Plans At-a-Glance for Medicare-Eligible Retirees” chart for deductible and coinsurance requirements.

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.

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.
**Lifetime Limits**

The University 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).

**Notice of Medical Plan Grandfather Status Under the Patient Protection and Affordable Care Act**

The University of Rochester believes that the University Complementary Care Plan with Major Medical and University Major Medical are “grandfathered health plans” 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 1-585-275-2084. 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.
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 4) 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 retiree’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, becoming unmarried, etc.);
- During the University’s annual Open Enrollment period.

The adult child or covered retiree will be required to pay 100% of the cost of the coverage. The coverage must be paid for fully in advance of a month of coverage.

The retiree 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 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.

**Important:** Please note that 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 participation in the plan after you would otherwise lose coverage by continuing to make payments to the plan, plus an administrative charge. 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.

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1 Only applies to dental plans, University Complementary Care Plan with Major Medical, and to the University Major Medical component of the Preferred Gold HMO-POS with University Major Medical. You can continue coverage in a Medicare Advantage plan without electing COBRA, because Medicare Advantage plans are provided through individual insurance policies. If you lose eligibility for University of Rochester Medicare-Eligible Retiree Plans while you are enrolled in a Medicare Advantage plan, then you qualify for a Special Election Period to enroll in another Medicare plan on a direct-bill basis. You would need to contact the Medicare plan providers directly to make arrangements for enrollment and premium payments.
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 spouse¹ 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?

Spouses of retirees may become qualified beneficiaries if they lose coverage under the plan because they become legally separated or divorced. In that case, the former spouse whose retiree health coverage under the plan would be terminated may continue such coverage for up to 36 months by electing and paying for continuation coverage as described below.²

Dependent children of retirees may become qualified beneficiaries if they lose coverage under the plan because any of the following Qualifying Events happen:

- The parent-retiree dies and there is no surviving parent covered under the plan, or if the surviving parent later dies; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

A child whose retiree health coverage under the plan would be reduced or terminated for these reasons may continue such coverage for up to 36 months by electing and paying for continuation coverage as described below.

In addition, if the University were to file a proceeding in bankruptcy under Title 11 of the United States Code, this could be a Qualifying Event with respect to retirees, spouses, and dependents. If that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan. Depending on the circumstances, continuation coverage may be available for the retiree’s or spouse’s lifetime.

¹ Under federal law, COBRA is limited to spouses. However, the University extends continuation coverage to domestic partners on the same terms as spouses.

² Surviving widows and widowers remain eligible for participation in the University Health Care Plans and therefore, would not need to elect COBRA continuation coverage. Please refer to the “Who Is Eligible for Benefits” section on page 4.
When Is COBRA Coverage Available?
To qualify for COBRA continuation coverage upon legal separation or divorce, the retiree or spouse must notify the Plan Administrator of the legal separation or divorce 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 retiree health coverage.

If notice is not received within that 60-day period, then all qualified beneficiaries will lose their right to elect COBRA. You must provide written notice to:

University of Rochester
Benefits Office
44 Celebration Drive, Suite 2300
PO Box 270453
Rochester, NY 14627-0453

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

If a COBRA Qualifying Event occurs related to a proceeding in bankruptcy, the retiree and qualified beneficiaries will be notified of their COBRA rights by the Plan Administrator.

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 retirees 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 retiree, 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.
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.

For this plan, the COBRA premium will be 102% of the full cost of plan coverage.

If continuation of retiree health 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.

If your spouse or dependent elects COBRA continuation and then fails to pay the premiums due within the initial 45-day grace period, or fails 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 your spouse to use 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 retired employees, the same changes will apply to individuals on COBRA continuation of retiree 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, then 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.

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; or
- the University ceases to provide any group health plan for its employees or retirees.

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 other 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.

If You Have Questions
Questions concerning your plan or your COBRA continuation coverage rights should be directed to the Benefits Office at 1-585-275-2084. 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.)
Claims and Appeals Procedures
You must submit claims for benefits under the plan according to the claims review procedure in the Evidence of Coverage (contract) or TPA's Benefits Booklet for the plan option you have elected. Claims must be submitted within the time specified in the Evidence of Coverage or TPA's Benefits Booklet. If the Evidence of Coverage or TPA's Benefits Booklet does not provide a deadline for submission, then you must submit your claim within one year from the date of the event that caused you to become eligible for benefits (for example, the date you received medical services).

Generally, you cannot commence a judicial proceeding against any person, including the plan, a plan fiduciary, the Plan Administrator, the Employer, or any other person, with respect to a claim for benefits without first exhausting the appropriate claims procedures. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim, may bring an action in an appropriate court to review the plan's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the date specified by the Evidence of Coverage or TPA's Benefits Booklet, or if no date is specified by those documents, by the second anniversary of the decision on appeal.

Additional Information Regarding Claims Review Procedure for the University Complementary Care Plan with Major Medical and University Major Medical
The procedures you need to follow to request health benefit coverage under this plan, either before or after health care has been provided, are governed by a detailed claims procedure required by federal regulations. This procedure describes where and when to submit claims, how to appeal denials of coverage, and other legal rights and obligations both you and the plan have with respect to benefit claims. This procedure should be read together with the material in this brochure. You may view or obtain a copy of the detailed claims procedure by contacting the Benefits Office at 1-585-275-2084 or online at www.rochester.edu/benefits. See Appendix B for more details.

Additional Information Regarding Claims Review Procedure for the Dental Plans
Excellus maintains a procedure under which a participant or beneficiary (or an authorized representative acting on behalf of a participant or beneficiary) may assert a claim for benefits. Any such claim shall be submitted to Excellus in writing. Excellus will generally notify you of its decision within 90 days after it receives the claim. However, if Excellus determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, Excellus will notify you in writing, before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which Excellus expects to render a decision.
If your claim is denied in whole or in part, Excellus will provide you with a written notice that explains the reason or reasons for the decision, includes specific references to plan provisions upon which the decision is based, provides a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information may be necessary), and describes the appeals procedures and applicable filing deadlines.

If you disagree with the decision reached by Excellus, you may submit a written appeal requesting a review of the decision. Your written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why you disagree with Excellus’ decision. You may submit written comments, documents, records, and other information relating to the claim, even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access to and copies of all documents, records, and other information relevant to the claim. Excellus will generally notify you of its decision on appeal within 60 days after the appeal is received.

Additional Information Regarding Claims Review Procedure for GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO
The GoldAnywhere PPO, Preferred Gold Standard HMO-POS, Preferred Gold HMO-POS, and USA Care PPO are Medicare Advantage plans. The appeals, grievance and claims review procedures are available in the Evidence of Coverage or by contacting MVP Health Care directly. (Please refer to page 2 for contact information.)

Claims Related to Plan Eligibility
If you are inquiring about your eligibility to participate in any part of the plan, you must submit a claim to the Plan Administrator in writing. See Appendix B for the applicable claims procedures.
Additional Plan Information

Plan Names and Numbers:
Health Care Plans for Faculty and Staff of the University of Rochester (Plan 517)
Dental Plans for Faculty and Staff of the University of Rochester (Plan 518)

Plan Sponsor Name:
University of Rochester

Plan Sponsor Federal Tax ID Number:
16-0743209

Plan Sponsor Address and Telephone Number:
c/o Office of Human Resources, Benefits Office
44 Celebration Drive, Suite 2300
PO Box 270453
Rochester, NY 14627-0453
Telephone: 1-585-275-2084

Plan Type
Plan 517 is a welfare plan that provides medical insurance.
Plan 518 is a welfare plan that provides dental insurance.

Cost, Funding and Type of Administration
The benefits under the University Complementary Care Plan with Major Medical, University Major Medical, and the dental plan are self-funded, and the University is responsible for paying claims under the plan out of its general assets. Benefits are not paid by an insurance company.

Other plan options provided by MVP Health Plan, Inc. are provided through insurance contracts. This means that the insurance company, not the University, is responsible for paying claims with respect to these plan options. Decisions regarding whether benefits are payable for a claim and the amount of benefits payable are made by the insurance company.

MVP Health Plan, Inc. is a not-for-profit HMO with a Medicare contract.

Retirees 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. The plan does not have a trust.

Keep Your Plan Informed of Address Changes
In order to protect your family’s rights, you should keep the Benefits Office and your insurer or TPA informed of any changes in the addresses of family members. Contact the Benefits Office at 1-585-275-2084 and the insurer or TPA listed on page 2.
Antiassignment 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.

Amendment and Termination
The University has adopted these plans with the intent of them being maintained for an indefinite period of time. Notwithstanding this intention, the University reserves the right to terminate any and/or all of the plans at any time. Moreover, the University has discretion to amend the cost sharing between participants and the University. The University has discretion to amend or terminate any of the plans from time to time, and at any time, including the discretion to change benefit levels or benefit availability or eligibility.

The University can change a policy with an insurance company only with the consent of the insurance company. Insurance companies can generally change their policies and contracts from time to time and may eliminate or reduce future coverage of certain benefits or change their procedures.

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, or (c) 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 from 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.
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 U.S. 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 Drive, Suite 2300
PO Box 270453
Rochester, NY 14627-0453

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/domestic partner or dependents. Medicare requires the University Health Care Plans to provide this information electronically through the TPAs. Historically, we only requested information for your spouse/domestic partner or dependent who was over age 45 or who was known to be covered by Medicare. Beginning in 2016, we need Social Security numbers for all enrolled dependents to comply with IRS reporting required by the Affordable Care Act. To view the CMS (Centers for Medicare & Medicaid Services) ALERT, which provides information on the authority for requesting the Social Security number, visit www.cms.hhs.gov/MandatoryInsRep. Go to the Downloads section and select the June 23, 2008 ALERT.
ERISA (Employee Retirement Income Security Act)

As a participant in the health care and dental plans, 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 University of Rochester 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.

Elimination of exclusionary periods of coverage for pre-existing conditions under your group plan.

Continue health care or dental coverage for yourself, spouse/domestic partner or dependent 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 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 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.

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 University of Rochester Benefits Office or the University Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 highly unlikely that disputes will require such action. However, if a situation occurs that simply is not covered by your plan, the claims review procedure should be able to meet the needs of any retiree. In extreme cases, if legal action seems necessary, the University Plan Administrator has been designated as the agent for service of the legal process.
Terms to Know

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: a regular weekly work schedule of at least 35 hours; for 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.

Grandparent Level—The Post-Retirement Benefits Program to which a Retiree is assigned, determined by the Retiree’s most recent date of Hire or Rehire, Continuous Employment, Retirement eligibility date, and Retirement date.

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.

HMO (Health Maintenance Organization)—In an HMO, care is offered through a network of participating providers, and the plan participant chooses a Primary Care Physician (PCP) to coordinate health care services. Preferred Gold Standard HMO-POS and Preferred Gold HMO-POS are Medicare Advantage HMOs.

HMO-POS (Health Maintenance Organization—Point of Service)—An HMO-POS offers the same benefits as an HMO and also includes some limited out-of-network benefits. Preferred Gold Standard HMO-POS and Preferred Gold HMO-POS are Medicare Advantage HMO-POS 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 accept discounted rates in return for your use of their services and because the benefit coinsurance is higher.

Layoff (indefinite)—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)—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—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 insurer or Third-Party Administrators (TPAs) to accept as payment.

Out-of-Network—Doctors, hospitals or other health care facilities that are not affiliated with the insurer or 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 generally 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)—In a PPO, members receive care from any licensed physician or medical facility of their choice as long as the provider accepts Medicare. GoldAnywhere PPO and USA Care PPO are PPOs.

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 (TPA) 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—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 or Retire—Ending of Appointment (whether voluntary or involuntary) at normal retirement age (as defined by the University of Rochester Retirement Program) 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 employment 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 benefits options.

**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 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 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**).

**TAR (Time As Reported)**—Appointment with (1) no regular schedule or (2) in which the individual is generally expected to work fewer than 17.5 hours per week in the case of hourly and professional, administrative, and supervisory staff, unless otherwise defined in collective bargaining agreements. For faculty it indicates that the individual carries less than half the normal (full) teaching and research load as defined for faculty by the college or school concerned.

**Temporary**—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**—Ending of Appointment for reason other than Retirement.

**Third-Party Administrator (TPA)**—A TPA processes health care claims and provides additional services for members in self-insured plan options. The University offers the choice of two TPAs to administer the University Complementary Care Plan and the medical portion of University Major Medical: Aetna or Excellus BlueCross BlueShield.

**University Benefit Plans**—Employee benefit plans sponsored by the University of Rochester, including Long-Term Disability plans (Plan 504, 512 or 521), Group Life Insurance (Plan 505), Travel Accident Insurance (Plan 506), Health Care Plans (Plan 509 or 517), Severance Pay (Plan 514), Employee Assistance Plan (Plan 515), Dental Plans (Plan 518), Long-Term Care Plan (Plan 519), Lifestyle Management Program (Plan 520), and the Retirement Program (Plan 003).

**University Dental Plans**—Employee benefit plans providing dental insurance benefits sponsored by the University of Rochester, through Plan 518.

**University Health Care Plans**—For purposes of this guide only, means employee benefit plans providing medical insurance benefits sponsored by the University of Rochester, including Plans 509 and 517.
When You Can Make Benefit Changes
Outside of Open Enrollment

You can only enroll in or change your health care plan options, or add eligible dependents to your health care plan 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. Please note that Medicare has additional rules that govern changing plan options, so if you are enrolled or would like to enroll in a Medicare Advantage plan, you can only change options if the change is also permitted by Medicare.
<table>
<thead>
<tr>
<th>You have the opportunity to change your benefits if…</th>
<th>Health Plan</th>
<th>Dental Plan (Traditional &amp; Medallion)</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>You get married or your domestic partner becomes eligible for benefits¹…</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 option and/or change your Third-Party Administrator.²</td>
<td>You may enroll or add coverage for your spouse or domestic partner and any newly eligible dependents. You may also change coverage to another plan option. You may discontinue coverage for you and any dependents that gain coverage under your spouse’s plan.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You have the opportunity to change your benefits if...</td>
<td>Health Plan</td>
<td>Dental Plan (Traditional &amp; Medallion)</td>
<td>Effective Date</td>
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<tr>
<td>You get divorced or legally separated, your marriage is annulled, or you end a domestic partnership¹...</td>
<td>You must discontinue coverage for your former spouse or domestic partner and any dependents that become ineligible (e.g., stepchildren or partners’ children). You may remove any dependents that will be added to your former spouse’s plan pursuant to a Qualified Medical Child Support Order. You may drop coverage for a legally separated spouse, or your legally separated spouse may remain on coverage until the divorce is final. You may enroll if you lost coverage under your former spouse’s or domestic partner’s plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former spouse’s or domestic partner’s plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order. You also may change coverage to another plan option and/or change your Third-Party Administrator.²</td>
<td>You must discontinue coverage for your former spouse or domestic partner and any dependents that become ineligible (e.g., stepchildren or partners’ children). You may remove any dependents that will be added to your former spouse’s plan pursuant to a Qualified Medical Child Support Order. You may drop coverage for a legally separated spouse, or your legally separated spouse may remain on coverage until the divorce is final. You may enroll if you lost coverage under your former spouse’s or domestic partner’s plan. You may add coverage for any eligible dependents that are no longer eligible for coverage under your former spouse’s or domestic partner’s plan or for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order. You also may change coverage to another plan option.</td>
<td>Date of event or date form is completed, whichever is later. (Any claims incurred on or after the date of ineligibility by the former spouse will not be paid by the plan.) Adding/removing eligible dependents: Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You have the opportunity to change your benefits if...</td>
<td>Health Plan</td>
<td>Dental Plan (Traditional &amp; Medallion)</td>
<td>Effective Date</td>
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<tr>
<td>Your eligible dependent passes away...</td>
<td>You may drop the deceased from coverage. You may enroll or add coverage for you 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 may drop the deceased from coverage. You may enroll or add coverage for you 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>Date of event.</td>
</tr>
<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 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 you and/or any affected dependents.</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. If you and/or your eligible dependents gain coverage under a spouse’s or domestic partner’s plan, you may discontinue coverage for you and/or any affected dependents.</td>
<td>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.</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>Date of event or date form is completed, whichever is later. (Any claims incurred on or after the date of ineligibility will not be paid by the plan with respect to ineligible dependents.)</td>
</tr>
<tr>
<td>You have the opportunity to change your benefits if...</td>
<td>Health Plan</td>
<td>Dental Plan (Traditional &amp; Medallion)</td>
<td>Effective Date</td>
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<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>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 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 and add coverage for your eligible dependent if the order requires you to provide coverage. You also may change coverage to another plan option. 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>Date required by court order or date order is determined by Plan Administrator to be qualified, whichever is later.</td>
</tr>
</tbody>
</table>
You have the opportunity to change your benefits if...

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Dental Plan (Traditional &amp; Medallion)</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>You, your current or former spouse (or his or her child who is a tax dependent), or current domestic partner (or his or her child), or your child changes coverage from another employer’s plan during the other employer’s open enrollment period that is different than the University’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. You may discontinue coverage for you and any dependents that gain coverage through the other employer’s plan.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<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>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You may discontinue coverage for you and any dependents that gain coverage through the other employer’s plan.</td>
<td>You may discontinue coverage for you and any dependents that gain coverage through the other employer’s plan.</td>
<td>Date of event or date form is completed, whichever is later.</td>
</tr>
<tr>
<td>You have the opportunity to change your benefits if...</td>
<td>Health Plan</td>
<td>Dental Plan (Traditional &amp; Medallion)</td>
</tr>
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<td>----------------------------------------------------------</td>
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<td>---------------------------------------</td>
</tr>
<tr>
<td>You or your eligible dependents lose eligibility for other employer group health plan coverage, governmental health insurance, or non-governmental health insurance through no fault of your own, exhaust COBRA coverage, or another employer ceases or significantly reduces 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.²</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.</td>
</tr>
<tr>
<td>You or your eligible dependents enroll in Medicaid...</td>
<td>Cancel or reduce coverage for individual who enrolled in Medicaid.</td>
<td>Cancel or reduce coverage for individual who enrolled in Medicaid.</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 (whomever lost the entitlement).³ You also may change coverage to another plan option and/or change your Third-Party Administrator.²</td>
<td>Enroll or increase coverage for yourself, your spouse, your domestic partner or your children (whomever lost the entitlement).</td>
</tr>
<tr>
<td>You have the opportunity to change your benefits if...</td>
<td>Health Plan</td>
<td>Dental Plan (Traditional &amp; Medallion)</td>
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<td>---------------------------------------------</td>
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</tr>
<tr>
<td>You or your eligible dependents become eligible for state premium assistance from 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 (whomever gained the entitlement). You also may change coverage to another plan option and/or change your Third-Party Administrator.</td>
<td>No change is permitted.</td>
</tr>
</tbody>
</table>

1 For rules regarding the eligibility of a domestic partner and/or their dependents, please refer to the “Domestic Partner Agreement Form” at www.rochester.edu/benefits/forms, or you may request a copy from the Benefits Office by phone (1-585-275-2084) or email (benefitoffice@hr.rochester.edu). In order to add a qualified domestic partner for coverage, the “Application for Domestic Partnership” form, along with a completed Benefits Program Qualifying Event Change form, must be submitted to and approved by the Benefits Office.

2 Please be aware that a change in TPA may result in administrative complications. You will need to notify your provider(s) of your TPA change to ensure that claims will be processed in a timely manner. Any prior approvals and pre-certifications will need to be re-established with your new TPA.

3 For this event, you must make your election within 60 days of the event with respect to medical coverage. All other events require you to make an election within 30 days of the event.
Appendix B

Post-Retirement Benefits Claims and Appeals Procedures

Eligibility Claims Procedures
Any participant (retiree) 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 Benefits Office will provide the Claimant, within the 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;
- 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 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 to 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 on 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

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

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 (e.g., Evidence of Coverage) or other materials from the Insurance Company (insurer) or Third-Party Administrator (TPA) and will be subject to the claims review procedure for that Program.

Certain benefits, including mental health and pediatric vision benefits, provided through the Medicare Advantage plans are supplemental with wrap-around coverage through the Major Medical Plan. Participants must file a claim form with the Benefits Office in order to obtain those supplemental benefits. The participant may obtain a claim form by contacting the Benefits Office at 1-585-275-3292. The claim must be filed in accordance with the instructions on the form to claim benefits.

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 starting on page 59 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 outlined starting on page 61, 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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Claims Reviewer</th>
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<tbody>
<tr>
<td>GoldAnywhere PPO, Preferred Gold HMO-POS, Preferred Gold Standard HMO-POS or USA Care PPO</td>
<td>MVP Health Care</td>
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<tr>
<td></td>
<td>Attention: Appeals Department</td>
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<tr>
<td></td>
<td>220 Alexander Street</td>
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<td></td>
<td>Rochester, NY 14607</td>
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<td></td>
<td>1-800-665-7924</td>
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<td></td>
<td><a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a></td>
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<tr>
<td>University Complementary Care Plan with Major Medical or University Major Medical (if Aetna is the TPA)</td>
<td>Aetna</td>
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<tr>
<td></td>
<td>1-877-864-4583</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>University Complementary Care Plan with Major Medical or University Major Medical (if Excellus is the TPA)</td>
<td>Excellus BlueCross BlueShield</td>
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<tr>
<td></td>
<td>165 Court Street</td>
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<tr>
<td></td>
<td>Rochester, NY 14647</td>
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<td></td>
<td>1-800-659-2808 or 1-585-232-2632</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></td>
<td>The denial notice will include the address where the appeal can be sent.</td>
</tr>
<tr>
<td>Wrap-Around Major Medical Plan (supplemental to Medicare Advantage Plans)</td>
<td>UR Benefits Office</td>
</tr>
<tr>
<td></td>
<td>44 Celebration Drive, Suite 2300</td>
</tr>
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<td></td>
<td>PO Box 270453</td>
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<td>Rochester, NY 14627-0453</td>
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<td></td>
<td>1-585-275-2084</td>
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<td></td>
<td>Facsimile 1-585-273-1054</td>
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<td></td>
<td><a href="mailto:benefitoffice@hr.rochester.edu">benefitoffice@hr.rochester.edu</a></td>
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<td></td>
<td><a href="http://www.rochester.edu/benefits">www.rochester.edu/benefits</a></td>
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<tr>
<td></td>
<td>Claimants may file a formal claim with the Benefits Office. The Manager of the Benefits Office will review all appeals.</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</td>
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<tr>
<td></td>
<td>Rochester, NY 14647</td>
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<tr>
<td></td>
<td>1-800-724-1675</td>
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<tr>
<td></td>
<td><a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a></td>
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<td></td>
<td><a href="http://www.rochester.edu/benefits/dental">www.rochester.edu/benefits/dental</a></td>
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<td></td>
<td>The denial notice will include the address where the appeal can be sent.</td>
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<tr>
<td>Prescription Drug Plan Coverage under the University Complementary Care Plan with Major Medical or University Major Medical</td>
<td>Aetna Pharmacy Management</td>
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<td></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>Excellus BlueCross BlueShield</td>
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<td></td>
<td>165 Court Street</td>
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<td>Rochester, NY 14647</td>
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<td>1-877-391-9296</td>
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<td><a href="http://www.excellusbcbs.com/ur">www.excellusbcbs.com/ur</a></td>
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<tr>
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<td>The denial notice will include the address where the appeal can be sent.</td>
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<td>Any claims related to other benefits described in this booklet</td>
<td>UR Benefits Office</td>
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<td>44 Celebration Drive, Suite 2300</td>
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<td>PO Box 270453</td>
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<td>Rochester, NY 14627-0453</td>
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<td>Facsimile 1-585-273-1054</td>
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<td><a href="mailto:benefitoffice@hr.rochester.edu">benefitoffice@hr.rochester.edu</a></td>
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<td><a href="http://www.rochester.edu/benefits">www.rochester.edu/benefits</a></td>
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<td>Claimants may file a formal claim with the Benefits Office. The Manager of the Benefits Office will review all appeals.</td>
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Default Claims Procedures for Group Health Plans (Health Plan, Prescription Drug Plan and Dental Plan)

This procedure applies only to claims submitted for Group Health Plan benefits under a Program. 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 pre-certification 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.

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. Out-of-network claims for Health Plan, Dental Plan, or Prescription Drug Plan benefits 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 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 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 timeframe for making a benefit 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 was 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 timeframe 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.

- **Urgent Care Claims**: The Claims Reviewer will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Reviewer will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the claim, unless the Claimant fails to submit information necessary to decide a claim. In this situation, the Claimant will be informed within 24 hours after submitting the claim of the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Claims Reviewer’s receipt of the requested information or the end of the period the Claimant was given to supply the additional information. In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant 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;
- 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 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 the Plan’s internal appeals procedures, any applicable external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- 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; and
- In the case of an adverse determination involving Urgent Care, a description of the expedited review process available for such claims.

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.

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.

D. Notification of Decision on Appeal

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.

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;
- References to the specific Plan provisions on which the benefit determination was based;
- 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.

**Claims for Other Benefits**

The following procedures apply for claims for other benefits described in this booklet that are not covered by the claims procedures for the Programs set forth above.

**A. Determination of Benefits**

Claims for other benefits described in this booklet shall 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 obtain an additional 90 days to decide the claim. Before obtaining this extension, 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 Benefits Office will provide the Claimant 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;

- 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;

- 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 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 to 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 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 is denied in whole or in part, 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 receiving the initial adverse decision. The 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 to 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 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.
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 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 on 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).

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 decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, 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.
This Guide summarizes the University of Rochester’s Health Care and Dental Plan options available for Medicare-eligible retirees, effective January 1, 2016. This Guide, together with the certificates of insurance or TPA’s Benefits Booklet, the enrollment package you receive each year, and any Summaries of Material Modifications (SMMs) published after this Guide, constitute the Summary Plan Description (“SPD”) for the Health Care Plans for Faculty and Staff of the University of Rochester (Plan 517) and the Dental Plans for Faculty and Staff of the University of Rochester (Plan 518) (the “Plan”).

In general, the Evidence of Coverage (contract), or TPA’s Benefits Booklet, describes the specific benefits that are provided by the Plan option, including any terms and conditions associated with those benefits. The annual enrollment package describes eligibility, cost sharing and other matters that relate to the terms and conditions of Plan participation in a particular year. This Guide describes supplemental information relevant to all Plan benefits; for example, the classes of employees eligible to participate and certain legally required statements about your benefits rights.

Subject to certain regulatory constraints, 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.

The official Plan document and the insurance documents published by the insurance companies, a copy of which may be obtained by contacting the Benefits Office, are the controlling legal documents for the Plan and will control in the event any provision of the SPD conflicts with those documents, or that any dispute arises regarding the terms and conditions of the Plan.