**UNIVERSITY OF ROCHESTER - Low Deductible Plan - over $45,100**

**Coverage Period:** 01/01/2013 - 12/31/2013

**Coverage for:** Individual + Family  **Plan Type:** POS

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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**Important Questions** | **Answers** | **Why this Matters:**
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What is the overall deductible? | For each Calendar Year, In-network: Individual $300/ Family $750; Out-of-network: Individual $600/ Family $1,500. Deductible applies to Medical coverage, it does not apply to preventive care. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

Are there other deductibles for specific services? | No. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.

Is there an out-of-pocket limit on my expenses? | Yes, In-network: Individual $1,500/ Family $3,750; Out-of-network: Individual $3,000/ Family $7,500. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Does this plan use a network of providers? | Yes. For a list of in-network providers, view your Third-Party Administrator's (TPA) website at: www.actna.com or www.excellusbcbs.com or call 1-888-982-3862 (Aetna) or 1-800-659-2808 (Excelsus). | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist? | No. You don’t need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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*Questions:* Call 1-888-982-3862 (Aetna) or 1-800-499-1275 (Excelsus) or visit us at www.HealthReformPlanSBC.com.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

#### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 10 visits per calendar year for Acupuncture.</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge except 10% coinsurance for Vision and Hearing Exam</td>
<td>Not covered except 40% coinsurance for Hearing Exam.</td>
<td>Age and frequency schedules may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Standard Excellus Pre-Authorization Radiology Management List Applies</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Standard Excellus Pre-Authorization Radiology Management List Applies</td>
</tr>
</tbody>
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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Retail Prescription $10 copay for up to a 30 day supply. Mail Order Prescription $25 copay for a 30-90 day supply.</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail Prescription $20 copay for up to a 30 day supply. Mail Order Prescription $50 copay for a 30-90 day supply.</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Retail Prescription $35 copay for up to a 30 day supply. Mail Order Prescription $87.50 copay for a 30-90 day supply.</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Diabetic insulin and supplies</td>
<td>Retail prescriptions 10% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs Generic/Preferred/Non-Preferred Brand</td>
<td>$10/$20/$35 copay for 30-day supply at a specialty pharmacy.</td>
<td>50% coinsurance if administered at a medical facility.</td>
<td>Limit one Retail supply at a network pharmacy. All other fills must be made at a Specialty Pharmacy. 20% coinsurance when administered at a medical facility.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>No coverage for non-urgent procedures.</td>
</tr>
</tbody>
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### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
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</thead>
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<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 45 visits per calendar year for Physical, Occupational and Speech Therapy, including outpatient hospital facility services.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 45 visits per calendar year for Physical, Occupational and Speech Therapy, including outpatient hospital facility services. May be other restrictions.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 120 days per calendar year maximum. Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Pre-authorization required for out-of-network care. Benefits will be reduced by $400 if pre-authorization is not obtained.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Coverage is limited to 1 routine vision exam per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>No charge</td>
<td>No charge</td>
<td>Coverage is limited to $60 combined maximum for all covered eyeglass lenses, contact lenses and frames per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered.</td>
</tr>
</tbody>
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UNIVERSITY OF ROCHESTER - Low Deductible Plan - over $45,100

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Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Weight loss programs
- Private duty nursing
- Routine foot care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture - Coverage is limited to 10 visits per calendar year.
- Bariatric surgery
- Chiropractic care
- Hearing aids - Coverage is limited to $600 maximum per child up to age 19 every 3 years.
- Infertility treatment - Cycle and dollar limits may apply.
- Routine eye care - Coverage is limited to 1 routine vision exam per calendar year.

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your respective Third Party Administrator at 1-888-982-3862 for Aetna and at 1-800-499-1275 for Excellus BlueCross BlueShield. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Your Grievance and Appeals Rights:**

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your respective Third Party Administrator: Aetna at 1-888-982-3862 or www.aetna.com or Excellus BlueCross BlueShield at 1-800-499-1275 or www.excellusbcbs.com/UR, or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Language Access Services:**

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862 (Aetna) or 1-800-499-1275 (Excellus).
Dinek'ehgo shika a'tobwol ninisingo, kwiijigo holne' 1-888-982-3862 (Aetna) or 1-800-499-1275 (Excellus).

如果需要中文的帮助，请拨打这个号码 1-888-982-3862 (Aetna) or 1-800-499-1275 (Excellus).
Para obtener asistencia en Español, llame al 1-888-982-3862 (Aetna) or 1-800-499-1275 (Excellus).

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

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Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $6,370
- Patient pays: $1,170

Sample care costs:

- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

Total $7,540

Patient pays:

- Deductibles $300
- Copays $20
- Coinsurance $700
- Limits or exclusions $150

Total $1,170

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $4,400
- Patient pays: $1,000

Sample care costs:

- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

Total $5,400

Patient pays:

- Deductibles $300
- Copays $400
- Coinsurance $220
- Limits or exclusions $80

Total $1,000

Note: Your plan may have both copays and coinsurance for covered services; if so, these examples use copays only. Your costs may be higher.

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### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?
- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

#### What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

#### Does the Coverage Example predict my own care needs?
- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?
- **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.