The University of Rochester Health Care Plans offer coverage to help meet the health care needs of you and your family. This chart is designed to supplement the 2013 Decision Guide for Medicare-Eligible Retirees, which can be found at www.rochester.edu/benefits/retirement/post-retirement or by calling 585-275-2084 to obtain a copy.
The University of Rochester is committed to providing comprehensive health care benefits to help meet the needs of you and your family. In addition, we want to help you become better informed about how the health care plans work so you can make good choices — both in choosing the right plan and then using it well.

This Health Care Plans Comparison Chart is designed to supplement the 2013 Health Program Decision Guide for Medicare-Eligible Retirees and highlights each of the health care plans that are available to you. We encourage you to review this chart carefully so that you can make the right choices that fit the needs of you and your family.
Enrollment

HOW TO ENROLL

If you decide that you want to make a change in your coverage, you need to submit completed enrollment form(s) to the Benefits Office, Box 636, Medical Center, G-8011, 260 Crittenden Boulevard, Rochester, NY 14642. You will need to complete two enrollment forms if you wish to change your own and your spouse’s health care plan coverage. Enrollment forms can be obtained from the Benefits Office.

Your enrollment form(s) must be received:
- By the end of the open enrollment period*, or
- Within 30 days of a qualifying event*.

*Enrollment applications for the Medicare Advantage plans (Medicare Blue Choice HMO-POS, Preferred Gold HMO-POS, GoldAnywhere PPO, 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 disenrollment form(s) prior to the effective date of disenrollment.

HEALTH PROGRAM RESOURCES

<table>
<thead>
<tr>
<th>If you have questions about…</th>
<th>Contact…</th>
</tr>
</thead>
</table>
| Medicare Blue Choice HMO-POS | Excellus BlueCross BlueShield  
165 Court St.  
Rochester, NY  14647  
1-877-883-9577  
(TTY 1-800-421-1220)  
www.excellusbcbs.com |
| GoldAnywhere PPO | MVP Health Care  
220 Alexander St.  
Rochester, NY  14607  
1-800-665-7924  
(TTY 1-800-662-1220)  
www.mvphealthcare.com |
| USA Care PPO | MVP Health Care  
220 Alexander St.  
Rochester, NY  14607  
1-888-597-4419  
(TTY 1-800-662-1220)  
www.mvphealthcare.com/usacare |
| 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 |
| University Complementary Care Plan with Major Medical | Depending on which TPA you choose:  
Aetna  
P.O. Box 981109  
El Paso, TX  79998-1109  
1-877-864-4583  
www.aetna.com  
Excellus BlueCross BlueShield  
165 Court St.  
Rochester, NY  14647  
1-800-659-2808 or 585-232-2632  
www.excellusbcbs.com  
Pharmacy Help Desk: 1-877-391-9296 |
| General Benefits | UR Benefits Office  
585-275-2084; Facsimile 585-273-1054  
beneftsoffic@hr.rochester.edu  
www.rochester.edu/benefits |
| Medicare | 1-800-MEDICARE (1-800-633-4227)  
(TTY 1-877-486-2048)  
www.medicare.gov |
Comparing the 2013 University Health Care Plans for Medicare-Eligible Retirees

Coordinates with Medicare and services are paid through Medicare first. Please see the “Medicare & You” handbook for more detailed information.

<table>
<thead>
<tr>
<th>University Complementary Care Plan with Major Medical</th>
<th>Preferred Gold HMO-POS with University Major Medical</th>
<th>USA Care PPO (with MVP Part D Prescription Drug)</th>
<th>Medicare Blue Choice HMO-POS (with Medicare Part D Prescription Drug)</th>
<th>GoldAnywhere PPO (with MVP Part D Prescription Drug)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residency Requirements</strong></td>
<td>None</td>
<td>United States or Puerto Rico</td>
<td>Excellus 6-county New York service area</td>
<td>MVP 17-county New York service area</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Applies only to Rx Drugs:</td>
<td>Applies to other covered Major Medical items:</td>
<td>Applies to other covered Major Medical items:</td>
<td>Applies to other covered Major Medical items:</td>
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<tr>
<td><strong>• Single</strong></td>
<td>$695</td>
<td>$695</td>
<td>$695</td>
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<tr>
<td><strong>• Family</strong></td>
<td>$1,390</td>
<td>$105</td>
<td>$105</td>
<td>$105</td>
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</tbody>
</table>

**Annual Stop Loss Protection for Major Medical**

| **Out-of-Pocket Maximum**                            | Applies only to Rx Drugs:                           | Applies to other covered Major Medical items:  | Applies to other covered Major Medical items:               | Applies to other covered Major Medical items:   |
| **• Single**                                          | $1,700                                               | $1,700                                          | $1,700                                                      | $1,700                                          |
| **• Family**                                         | $4,300                                               | $400                                            | $300                                                        | $300                                            |

**Annual Stop Loss Protection for Medicare Advantage Plans**

| **Out-of-Pocket Maximum**                            | Applies only to Rx Drugs:                           | Applies to the Preferred Gold HMO-POS portion of the plan for all co-pays and co-insurance for covered medical services (except acupuncture, prescription drugs, and covered Major Medical expenses): | Applies only to Rx Drugs: After annual out-of-pocket prescription drug maximum of $4,750, you pay the greater of: $2.65 for generics/$6.60 for brand-name drugs or 5% co-insurance: | Applies only to Rx Drugs: After annual out-of-pocket prescription drug maximum of $4,750, you pay the greater of: $2.65 for generics/$6.60 for brand-name drugs or 5% co-insurance: |
| **Out-of-Pocket Maximum**                            | $4,000                                               | $4,000                                          | $4,000                                                      | $4,000                                          |

**Point-of-Service Benefit**

| **Out-of-Network**                                   | 30% coinsurance; $5,000 limit per calendar year    | N/A                                             | N/A                                                         | N/A                                             |

**INPATIENT HOSPITAL BENEFITS**

| **Semi-private Room and Board**                      | Covered in full                                     | $100 co-pay for each Medicare-covered hospital stay; maximum 3 co-pays per year then covered at 100% | $250 co-pay for each Medicare-covered stay at a network hospital; maximum 2 co-pays per year | Covered in full in-network; covered at 80% out-of-network |
| **Physician and Surgeon Services**                   | Covered in full                                     | Covered in full                                 | Covered in full                                             | Covered in full in-network; covered at 80% out-of-network |

**OUTPATIENT HOSPITAL BENEFITS**


Applies only to Rx Drugs:

After annual

University Complementary
Preferred Gold HMO-POS
USA Care PPO
GoldAnywhere PPO

$4,000

Part D Prescription Drug

Applies only to Rx

Drugs:

Residency Requirements

Applies to other covered Major Medical items:

Annual Stop Loss Protection for  Major Medical
(Out-of-Pocket Maximum)

Annual Stop Loss Protection for Medicare Advantage Plans

Emergency Care

Covered at 80% after Major Medical deductible, less any Medicare payment

$65 co-pay per visit if not followed by hospitalization within 24 hours

$65 co-pay per visit if not followed by hospitalization within 24 hours

$50 co-pay per visit if not followed by hospitalization within 23 hours

$65 co-pay per visit if not followed by hospitalization within 24 hours, in- and out-of-network

Urgent Care Center

Covered at 80% after Major Medical deductible, less any Medicare payment

$15 co-pay per visit

$20 co-pay per visit

$20 co-pay per visit

$15 co-pay per visit, in- and out-of-network

Ambulance

Covered in full for emergency use and medically necessary transfers, less any Medicare payment

$50 co-pay for emergency use, covered at 80% after Major Medical deductible for medically necessary transfers

$35 co-pay for emergency use

$50 co-pay for emergency use

$35 co-pay for emergency use in- and out-of-network

MENTAL HEALTH CARE

Inpatient

Covered Medicare Part A inpatient deductible and co-pay up to 120 days per calendar year, additional days covered at 80% after Major Medical deductible, less any Medicare payment

Covered in full, 190-day lifetime maximum in psychiatric hospital, additional days covered at 80% after Major Medical deductible, less any Medicare payment

$100 co-pay for each Medicare-covered hospital stay, maximum 3 co-pays per year, 190-day lifetime maximum in psychiatric hospital

$250 co-pay for each Medicare-covered stay at a network hospital, maximum 2 co-pays per year; 190-day lifetime maximum in psychiatric hospital

Covered in full in-network, 190-day lifetime maximum in psychiatric hospital, covered at 80% out-of-network

Outpatient

Covered at 80% after Major Medical deductible, less any Medicare payment. Includes coverage for autism the same as any other illness.

$15 co-pay per visit

$20 co-pay per visit

35% co-insurance

$15 co-pay in-network

$25 co-pay out-of-network

ALCOHOL/SUBSTANCE ABUSE CARE

Inpatient

Covered Medicare Part A inpatient deductible and co-pay up to 120 days per calendar year, additional days covered at 80% after Major Medical deductible, less any Medicare payment

Covered in full

$100 co-pay for each Medicare-covered hospital stay, maximum 3 co-pays per year

$250 co-pay for each Medicare-covered stay at a network hospital, maximum 2 co-pays per year

Covered in full in-network, covered at 80% out-of-network

Outpatient

Covered at 80% after Major Medical deductible, less any Medicare payment

$15 co-pay per visit

$20 co-pay per visit

35% co-insurance

$15 co-pay per visit in-network

$25 co-pay per visit out-of-network

PRESCRIPTION DRUGS

Non-Maintenance Drugs
Covered at 80% after Prescription Drug deductible
Tier 1: $10
Tier 2: $20
Tier 3: $40
Tier 4: $60
Retail (30-day supply co-pay)

Tier 1: $10
Tier 2: $20
Tier 3: $40
Tier 4: $60
Mail Order (up to 90-day supply co-pay)

Tier 1: $10
Tier 2: $20
Tier 3: $40
Tier 4: $60
Mail Order (30-day supply co-pay)

Tier 1: $10
Tier 2: $20
Tier 3: $40
Tier 4: $60
Mail Order (30-day supply co-pay)

Tier 1: $10
Tier 2: $20
Tier 3: $40
Tier 4: $60
Mail Order (up to 90-day supply co-pay)
### Diabetic Equipment and Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Tier 1: $10</th>
<th>Tier 2: $30</th>
<th>Tier 3: $60</th>
<th>Tier 4: $60</th>
<th>Tier 5: $0</th>
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<tbody>
<tr>
<td>Oral medications</td>
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<td>Oral medications</td>
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<td>Needles and syringes</td>
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<td>Needles and syringes</td>
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<td>Test strips for insulin</td>
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<td>Glucose tablets</td>
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<td>Hospice Care</td>
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<td>Vision Care</td>
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<td>Vision Care</td>
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<td>Hearing Care</td>
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<td>Hearing Care</td>
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<tr>
<td>Serum covered in full; $10-15 office visit co-pay</td>
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<td>Serum covered in full; $10-15 office visit co-pay</td>
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<td>Hearing aids covered with a $600 allowance every 3 years</td>
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<tr>
<td>Hearing aids covered with a $600 allowance every 3 years</td>
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<tr>
<td>Hearing aids covered with a $300 allowance every 2 years</td>
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<tr>
<td>Hearing aids covered with a $300 allowance every 2 years</td>
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<tr>
<td>Hearing aids covered with a $600 allowance every 3 years</td>
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<tr>
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<tr>
<td>Hearing aids covered with a $600 allowance every 3 years</td>
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</tbody>
</table>

### OTHER SERVICES

#### Skilled Nursing Facility Care (excludes custodial care)

<table>
<thead>
<tr>
<th>Coverage Details</th>
<th>Covered in full, days 1-20, days 21-100, $135 co-pay per day</th>
<th>Covered in full for days 1-20, days 21-100</th>
<th>Covered in full for days 1-20, days 21-100, $135 co-pay per day</th>
<th>Covered in full for days 1-20, 50% co-insurance for days 21-100</th>
<th>Covered in full in-network for days 1-100, covered at 80% out-of-network for days 1-100</th>
</tr>
</thead>
</table>

#### Home Health Care

- Covered in full (deductible waived), less any Medicare payment. Includes visiting nurse care. Each visiting nurse care of four hours or less count as one home health visit. Each such shift of over four hours and up to eight hours counts as two home health care visits.

#### Hospice Care

- Covered in full, less any Medicare payment

#### Vision Care

- No coverage

- Exams once a year-$15 co-pay;

- Eye wear - $100 allowance every year, 20% discount on lenses and frames at participating optical providers

- Exams once a year-$20 co-pay;

- Eye wear - $100 allowance every year, 20% discount on lenses and frames at participating optical providers

- $15 co-pay per visit for disease or injury; eye wear after cataract surgery covered at 80% after Major Medical deductible, less any Medicare payment

- $20 co-pay per visit for disease or injury; eye wear after cataract surgery covered at 80% after Major Medical deductible, less any Medicare payment

- $20 co-pay per visit for disease or injury; eye wear after cataract surgery covered at 80% after Major Medical deductible, less any Medicare payment

#### Hearing Care

- No coverage for routine care

- Diagnostic evaluations covered at 80% after Major Medical deductible, less any Medicare payment

- Hearing aids covered with a $600 allowance every 3 years

- Hearing aids covered with a $600 allowance every 3 years

- Hearing aids covered with a $600 allowance every 3 years

- Hearing aids covered with a $600 allowance every 3 years

- Hearing aids covered with a $600 allowance every 3 years

- Hearing aids covered with a $600 allowance every 3 years
### Durable Medical Equipment (DME)
- Covered in full after Major Medical deductible, less any Medicare payment
- Covered at 80% if purchased from participating provider; balance covered at 100% after Major Medical deductible
- Covered at 80% if purchased from participating provider
- Covered at 80% if purchased from participating provider
- Covered at 80% in- and out-of-network if purchased from participating provider

### Allergy Tests and Injections
- Covered at 80% after Major Medical deductible, less any Medicare payment
- Serum covered in full, $10-$15 office visit co-pay may apply
- Serum covered in full, $15-$20 office visit co-pay may apply
- Serum covered in full, $10-$15 office visit co-pay may apply in-network, $25 co-pay out-of-network

### Chiropractic Care
- Covered at 80% after Major Medical deductible, less any Medicare payment (based on medical necessity)
- $15 co-pay per visit
- $20 co-pay per visit
- $20 co-pay per visit
- $15 co-pay per visit in-network, $20 co-pay per visit out-of-network

### Acupuncture
- Covered at 80% after Major Medical deductible, if performed by a licensed physician to treat a diagnosis
- Covered at 50% for up to 10 visits per year (additional visits covered at 80% after Major Medical deductible only if performed by a licensed physician to treat a diagnosis)
- Covered at 50% for up to 10 visits per year
- Covered at 50% for up to 10 visits per year
- Covered at 50% for up to 10 visits per year

### Podiatry
- Covered at 80% for medically necessary foot care, less any Medicare payment
- $15 co-pay for each Medicare-covered visit (medically necessary foot care)
- $20 co-pay for each Medicare-covered visit (medically necessary foot care)
- $20 co-pay for each Medicare-covered visit (medically necessary foot care)
- $15 co-pay for each Medicare-covered visit in-network, $25 co-pay for each Medicare-covered visit out-of-network (medically necessary foot care)

## PREVENTIVE SERVICES

### Physicals
- Covered in full (annual GYN exam covered in full), less any Medicare payment, one allowed per year
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Pap Smears and Pelvic Exams
- Covered in full, less any Medicare payment, one allowed per year
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Mammograms
- Covered in full for annual screening, less any Medicare payment
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Bone Mass
- Covered in full, less any Medicare payment
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Colorectal Screening Exams
- Covered in full for flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, less any Medicare payment
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Prostate Cancer Screening Exams
- Covered in full, less any Medicare payment, one allowed per year
- Covered in full
- Covered in full
- Covered in full
- Covered in full

### Immunizations
- Covered in full for pneumonia, flu, H1N1, shingles, tetanus and Hepatitis B vaccines, less any Medicare payment
- Covered in full for the pneumonia, flu, H1N1 and Hepatitis B vaccines. Shingles and tetanus vaccines covered in full under Major Medical plan.
- Covered in full for the pneumonia, flu, H1N1, and Hepatitis B vaccines; office visit co-pay may apply
- Covered in full for the pneumonia, flu, H1N1, and Hepatitis B vaccines; office visit co-pay may apply
- Covered in full for the pneumonia, flu, H1N1 and Hepatitis B vaccines; office visit co-pay may apply

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1. The University Complementary Care Plan and University Major Medical will not duplicate benefits provided by Medicare Part A, Part B, or Part D. These plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act.
2. Specialty Drug Program: Specialty Drug prescriptions must be filled through a specific pharmacy designated by your Pharmacy Benefits Manager.
3. In cases of selected brand-name drugs where there is an FDA-approved generic substitute available, your benefit will be based on the cost of the generic drug rather than the cost of the brand-name drug. If you or your doctor choose the brand-name drug, you will have to pay the difference, plus any applicable co-payments.
4. If your prescription does not have an approved generic substitute, your benefit will not be affected. As new drugs are approved by the government (the Food and Drug Administration, or FDA) the plan will determine the possibility of covering the drug, including researching its value, safety, and possible advantages over existing covered drugs. The plan will also determine any limits to covering the new drug.
5. If you are eligible for special assistance due to limited income, you may receive lower prescription drug co-pays.
6. §§ The Shingles and Tetanus vaccines are covered under the Part D (prescription drug) portion of the plan.
Plan Information

The University Plan Administrator for Health Care Plans Coverage is:
Associate Vice President of Human Resources
University of Rochester (ID No. 16-0743209)
Office of Human Resources Benefits Office
260 Crittenden Boulevard
Rochester, NY 14642
Telephone: 585-275-2084

The Plan Year is from January 1 to December 31
The Plan Number is 517

This chart summarizes the University of Rochester’s Health Care Plans as in effect on January 1, 2013. Subject to certain regulatory constraints, the University reserves the right to modify, amend, or terminate the plans at any time, including action that may affect coverage, cost-sharing, or covered benefits, as well as benefits that are provided to current and future retirees.