Schedule of Benefits

Employer:	**University of Rochester**
ASA:	700143
Control:	878253
Issue Date:	April 13, 2018
Effective Date:	January 1, 2018
Schedule:	8A
Booklet Base:	8

For: University Major Medical Plan for PCG

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Comprehensive Medical Plan

PLAN FEATURES	
Calendar Year **Deductible***	$123
Family Deductible*	$246
Common Accident Deductible	$123

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit: $300

Family Maximum Out of Pocket Limit: $600

PLAN FEATURES	
Lifetime Maximum Benefit per person	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, and the remaining Payment Percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

PLAN FEATURES	
Preventive Care Benefits	
Routine Physical Exams	
Office Visits.	100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *log onto the Aetna website www.aetna.com or call the number on the back of your ID card.*
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit
Preventive Care Immunizations *Performed in a facility or* ***physician's*** *office*	100% per visit No **copay** or **deductible** applies.
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No **copay** or **deductible** applies.
Obesity Maximum Visits per Calendar Year *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only* 10 *visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)* *** ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.***
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits *** ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.***
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits *** ***Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.***

Sexually Transmitted Infections Benefit Maximums Maximum Visits per Calendar Year	2 visits*****

Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.

Well Woman Preventive Visits ***Office Visits***	100% per visit No Calendar Year deductible applies.
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings ***Outpatient***	100% per visit No Calendar Year **deductible** applies.
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *log onto the* ***Aetna*** *website www.aetna.com, or call the number on the back of your ID card.*
Lung Cancer Screening Maximum	One screening every 12 months*****

Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

Prenatal Care ***Office Visits***	100% per visit No **deductible** applies.

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services	
Lactation Counseling Services - *Facility or Office Visits*.	100% per visit No **deductible** applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months
***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.	

Breast Pumps & Supplies	100% per item No **deductible** applies.
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.	

Family Planning Services - Female Contraceptives	
Female Contraceptive Counseling Services - Office Visits.	100% per visit No **deductible** applies.

Contraceptive Counseling Services Maximum Visits either in a group or individual setting	2* visits per 12 months
*****Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.	

Family Planning Services - Female Contraceptives	
Female Contraceptive Counseling Services - Office Visits.	100% per visit No **deductible** applies.

Contraceptive Counseling Services Maximum Visits either in a group or individual setting	2* visits per 12 months
*****Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.	

Family Planning - Female Voluntary Sterilization	
Inpatient	100% per visit No **deductible** applies.
Outpatient	100% per visit No **deductible** applies.

Family Planning Services - Female Contraceptives	
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item No **copay** or **deductible** applies.

Family Planning Services - Other	
Voluntary Sterilization for Males	
Outpatient	80% per visit after Calendar Year **deductible**
Voluntary Termination of Pregnancy	
Outpatient	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Urgent Medical Services	
Urgent Medical Care *(at a non-hospital free standing urgent care facility)*	80% per visit after Calendar Year **deductible**
Urgent Medical Care *(for other than a non-hospital free standing facility)*	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Inpatient Facility Expenses	
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year **deductible starting on the 121st day**
Private Duty Nursing (Outpatient)	80% per visit after Calendar Year **deductible**

Hospice Benefits	
Hospice Care – Facility Expenses (Room & Board)	80% per admission after Calendar Year **deductible**
Hospice Care (Other Expenses during a stay)	80% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days
Hospice Outpatient Visits	80% per visit after Calendar Year **deductible**

PLAN FEATURES	
Inpatient Treatment of Mental Disorders	
Mental Disorders	
Room and Board	80% after the Calendar Year **deductible**
Other than Room and Board	80% after the Calendar Year **deductible**

Inpatient Residential Treatment Facility	80% per admission after Calendar Year **deductible starting on the 121st day**

Outpatient Treatment of Mental Disorders

Outpatient Services	80% per visit after Calendar Year **deductible**

PLAN FEATURES
Other Covered Health Expenses

Acupuncture	80% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	80% after Calendar Year **deductible**
Durable Medical and Surgical Equipment	100% per item after Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES
Outpatient Therapies

Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.

Pharmacy Benefit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prescription Drug Calendar Year Deductible		
Individual	$811	Not Covered
Family	$1,622	Not Covered

Network Prescription Drug Calendar Year Deductible
The individual **network prescription drug** calendar year **deductible** applies separately to you and each of your covered dependents. The family **network prescription drug** calendar year **deductible** applies to you and your covered dependents combined. After **network prescription drug covered expenses** reach the **prescription drug** calendar year **deductible**, the plan will begin to pay benefits for **network prescription drug covered expenses** for the rest of the calendar year. The **network prescription drug** calendar year **deductible** applies to all **network prescription drug covered expenses** except diabetic drugs and supplies and oral and injectable chemotherapy drugs.

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	20% of the **negotiated charge**	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	20% of the **negotiated charge**	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	20% of the **negotiated charge**	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	20% of the **negotiated charge**	Not Covered
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	20% of the **negotiated charge**	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	20% of the **negotiated charge**	Not Covered

Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	20% of the **negotiated charge**	Not Covered
For more than a 30 day supply but less than a 91 day supply (mail order)	20% of the **negotiated charge**	Not Covered

UNIVERSITY OF ROCHESTER PHARMACY	**PER PRESCRIPTION COPAY**

Preferred Generic Prescription Drugs	
For each 30 day supply (retail)	15% of the **negotiated charge** after Calendar Year **deductible**
For more than a 30 day supply but less than a 91 day supply (mail order)	15% of the **negotiated charge** after Calendar Year **deductible**

Preferred Brand-Name Prescription Drugs	
For each 30 day supply (retail)	15% of the **negotiated charge** after Calendar Year **deductible**
For more than a 30 day supply but less than a 91 day supply (mail order)	15% of the **negotiated charge** after Calendar Year **deductible**

Non-Preferred Generic Prescription Drugs	
For each 30 day supply (retail)	15% of the **negotiated charge** after Calendar Year **deductible**
For more than a 30 day supply but less than a 91 day supply (mail order)	15% of the **negotiated charge** after Calendar Year **deductible**

Non-Preferred Brand-Name Prescription Drugs	
For each 30 day supply (retail)	15% of the **negotiated charge** after Calendar Year **deductible**
For more than a 30 day supply but less than a 91 day supply (mail order)	15% of the **negotiated charge** after Calendar Year **deductible**

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

Copay and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** calendar year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs;** contraceptive devices;
- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide **out-of-network pharmacy** benefits under the Prescription Drug Plan, the per **prescription copay/deductible** and any applicable **prescription drug** calendar year **deductible** continue to apply.

The per **prescription copay/deductible** and any **prescription drug** calendar year **deductible** continue to apply:

- For contraceptive methods that are:
  - **brand-name prescription drugs** and brand name devices and
  - FDA-approved female brand-name emergency contraceptives,

  that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail **pharmacy**	100% per supply No **copay** or **deductible** applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No **copay** or **deductible** applies.	Not covered.
Important Note: This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.		
Preventive Care Drugs and Supplements Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines	100% per item. No **copay** or **deductible** applies.	Not Covered.

and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.		

Important Note:
Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. Maximums: Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.	100% per supply No **copay** or **deductible** applies.	Not covered.

Coinsurance

	NETWORK	**OUT-OF-NETWORK**
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	Not Covered

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Prescription Drug Maximum Out of Pocket Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug **Maximum Out of Pocket Limit**	$1,700 Individual $3,400 Family	Not Covered Not Covered

Individual Prescription Drug Maximum Out of Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Network Prescription Drug Maximum Out of Pocket Limit
When your share or your covered dependent's share of **network prescription drug covered expenses** reach the **prescription drug network Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of that person's **network prescription drug covered expenses** for the rest of the calendar year.

Out-Of-Network Prescription Drug Maximum Out of Pocket Limit
When your share or your covered dependent's share of **out-of-network prescription drug covered expenses** reach the **out-of-network prescription drug Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of that person's **out-of-network prescription drug covered expenses** for the rest of the calendar year.

Family Prescription Drug Maximum Out of Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Network Prescription Drug Maximum Out of Pocket Limit
When your share and your covered dependents share of **network prescription drug covered expenses** combined reach the family **prescription drug Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the calendar year.

When two or more family members share of **network prescription drug covered expenses** reach the individual **prescription drug Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of the family's **network prescription drug covered expenses** for the rest of the calendar year.

Out-Of-Network Prescription Drug Maximum Out of Pocket Limit
When your share and your covered dependents share of **out-of-network prescription drug covered expenses** combined reach the family **prescription drug Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of the family's **out-of-network prescription drug covered expenses** for the rest of the calendar year.

When two or more family members share of **out-of-network prescription drug covered expenses** reach the individual **prescription drug Maximum Out of Pocket Limit** in a calendar year, your plan will pay 100% of the family's **out-of-network prescription drug covered expenses** for the rest of the calendar year.

Excluded Covered Expenses
Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** out-of-pocket limit and the family prescription **drug** out-of-pocket limit. These include:

Diabetic drugs and supplies
Expenses above the **recognized charge**.
Expenses incurred because you failed to obtain any necessary **precertification**.
Non-**covered expenses**.

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

All **covered expenses** accumulate toward the **deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits.*

You and each of your covered dependents have separate calendar year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family calendar year **deductibles**.

Calendar Year Deductible

Individual
This is an amount of **covered expenses** incurred each calendar year for which no benefits will be paid. This calendar year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the calendar year **deductible**, this Plan will begin to pay benefits for **covered expenses** for the rest of the calendar year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual calendar year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the calendar year, the following must happen:

Two covered persons must individually meet their calendar year **deductible** in a calendar year.

When this occurs in a calendar year, the individual calendar year **deductibles** for you and your covered dependents will be considered to be met for the rest of the calendar year.

Common Accident Deductible Limit
This limit applies when two or more family members are injured in the same accident. The common accident **deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **deductible** limit benefit amount paid for the same **covered expenses**.

Deductible Carryover
Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductible** will also count toward the following year's Calendar Year **deductible**.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out of Pocket Limit
The **Maximum Out of Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out of Pocket Limit**. As to the individual **Maximum Out of Pocket Limit**, each of you must meet your **Maximum Out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out of Pocket Limit**. See list below.

Individual
Once the amount of eligible expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year for that person.

Family Maximum Out of Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **Maximum Out of Pocket Limit,** these expenses will also count toward a family **Maximum Out of Pocket Limit**.

To satisfy this family **Maximum Out of Pocket Limit**, for the rest of the Calendar Year, the following must happen:

> Two family members have individually satisfied their individual **Maximum Out of Pocket Limit** in a Calendar Year. Once these family members have each satisfied their individual **Maximum Out of Pocket Limit**, the individual **Maximum Out of Pocket Limit** is considered met for the remaining family members for the rest of the Calendar Year.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.