Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2019 - 12/31/2019

UNIVERSITY OF ROCHESTER : University Complementary Care Plan with Major Medical

Coverage for: Individual + Family | **Plan Type:** Indemnity

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.rochester.edu/benefits** or by calling **1-585-275-2084**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-585-275-2084 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual $126 / Family $252.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. For prescription drugs- Individual $829/ Family $1,658. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual $300 / Family $600. Prescription drugs: Individual $1,700/ Family $3,400.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What you will pay	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	None
	Specialist visit	20% coinsurance	None
	Preventive care / screening / immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus or www.excellusbcbs.com	Generic drugs	20% coinsurance, after specific deductible (retail & mail order)	Covers 30 day supply (retail & mail order), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics. Deductible waived for diabetic drugs & supplies.
	Preferred brand drugs	20% coinsurance, after specific deductible (retail & mail order)	
	Non-preferred brand drugs	20% coinsurance, after specific deductible (retail & mail order)	
	Specialty drugs	20% coinsurance, after specific deductible (retail & mail order)	First prescription fill at a retail pharmacy or specialty pharmacy. All other fills must be made at a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	None
	Physician/surgeon fees	No charge	None
If you need immediate medical attention	Emergency room care	No charge	No coverage for non-emergency use.
	Emergency medical transportation	No charge	None
	Urgent care	20% coinsurance	None

Common Medical Event	Services You May Need	What you will pay	Limitations, Exceptions & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for 120 days; 20% coinsurance thereafter	None
	Physician/surgeon fees	No charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	None
	Inpatient services	No charge for 120 days; 20% coinsurance thereafter	None
If you are pregnant	Office visits	No charge	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalty of $400 for failure to obtain pre-authorization for care may apply. 120 days/calendar year.
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	No charge for 120 days; 20% coinsurance thereafter	
If you need help recovering or have other special health needs	Home health care	No charge	None
	Rehabilitation services	20% coinsurance	None
	Habilitation services	20% coinsurance	Age and coverage limits may apply
	Skilled nursing care	No charge for 120 days; 20% coinsurance thereafter	None
	Durable medical equipment	0% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered.
	Children's glasses	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult & Child)	• Routine eye care (Adult & Child)	• Weight loss programs
• Glasses (Child)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Glasses (Adult) – after cataract surgery only	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Hearing Aids – after accidental injury only	• Private-duty nursing
• Chiropractic Care	• Infertility Treatment	

Your Rights to Continue Coverage:

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

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

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

Your Grievance and Appeals Rights:

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

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

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

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

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

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

Assistive Technology

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

Smartphone or Tablet

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

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

About these Coverage Examples:

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

Peg is Having a baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$123
Specialist coinsurance	20%
Hospital (facility) coinsurance	No
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$280**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$123
Specialist coinsurance	20%
Hospital (facility) coinsurance	No
Other copayment	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$123
Specialist coinsurance	20%
Hospital (facility) coinsurance	No
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$190**

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.
*Note: This **plan** has other **deductibles** for specific services included in this coverage example. See "Are there other **deductibles** for specific services?"

The **plan** would be responsible for the other costs of these EXAMPLE covered services.