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.com 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)	Not covered	Not covered.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus or excellusbcbs.com	Generic drugs	20% coinsurance, after specific deductible (retail & mail order)	Covers 30 day supply (retail), 31-90 day supply (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. Diabetic drugs & supplies aren't subject to the deductible.
	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)	Not covered	Not covered.
	Physician/surgeon fees	Not covered	Not covered.
If you need immediate medical attention	Emergency room care	Not covered	Not covered.
	Emergency medical transportation	20% coinsurance	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)	Not covered for first 120 days, 20% coinsurance thereafter	None
	Physician/surgeon fees	Not covered	Not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	None
	Inpatient services	Not covered for first 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).
	Childbirth/delivery professional services	Not covered	
	Childbirth/delivery facility services	Not covered for first 120 days, 20% coinsurance thereafter	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40 visits/calendar year. Each visiting nursing care of 4 hours or less equals 1 home health care visit. Each visit of 4 hours and up to 8 hours equals 2 home health care visits.
	Rehabilitation services	20% coinsurance	None
	Habilitation services	20% coinsurance	Age and coverage limits apply.
	Skilled nursing care	Not covered for first 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	Not covered	Not covered.
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
- Dental care (Adult & Child)
- Diagnostic test (x-ray, blood work)
- Emergency room care
- Glasses (Child)
- Hospice services
- Imaging (CT/PET scans, MRIs)
- Long-term care
- Outpatient physician/surgeon fees
- Outpatient surgery facility fee
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids - Accidental injury only.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 (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.

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 BlueCross BlueShield 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 for Aetna and 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	Not
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	$3,500
The total Peg would pay is	$3,720

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	Not
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	$200
The total Joe would pay is	$500

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	Not
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	$200
What isn't covered	
Limits or exclusions	$800
The total Mia would pay is	$1,100

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 (prescription drugs) 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.