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?	None.	See the Common Medical Events chart below for services this **plan** covers. See your Medicare Advantage Plan (MAP) Description for any **deductibles** that may apply to MAP portion of the **plan**.
Are there services covered before you meet your deductible?	No.	See MAP Description for coverage under MAP portion of **plan**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services. See your MAP Description for any deductibles for specific services that may apply to the MAP potion of the plan.
What is the out-of-pocket limit for this plan?	Individual $6,600 / Family $13,200.	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. See your MAP Description for any other **out-of-pocket limit** that may apply to the MAP portion of the **plan**. All expenses that count toward the **out-of-pocket limit** for the MAP portion of the plan count toward the **out-of-pocket limit** for this **plan**.
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. See your MAP Description for any **specialist** referral requirements that may apply to the MAP portion of the **plan.**

This summary is only for the Wrap-Around Major Medical portion of this plan which supplements USA Care PPO, GoldAnywhere PPO, or Preferred Gold Standard HMO-POS (each a "MAP"). For a description of benefits covered under the MAP portion of the plan, please refer to the Evidence of Coverage available for the applicable MAP by contacting MVP at 1-800-665-7924 (the "MAP Description").

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	Not covered	See MAP Description for coverage under MAP portion of **plan**.
	Specialist visit	Not covered	
	Preventive care / screening / immunization	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	
If you need drugs to treat your illness or condition	Generic drugs	Not covered	
	Preferred brand drugs	Not covered	
	Non-preferred brand drugs	Not covered	
	Specialty drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	
	Physician/surgeon fees	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	
	Emergency medical transportation	Not covered	
	Urgent care	Not covered	

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	See MAP Description for coverage under MAP portion of **plan**.
	Physician/surgeon fees	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	
	Inpatient services	No charge or 20% coinsurance	No charge after lifetime maximum is met under USA Care PPO or Preferred Gold Standard HMO-POS; 20% **coinsurance** after lifetime maximum is met under GoldAnywhere PPO if out-of-network **provider** is used (otherwise no charge). See MAP Description for additional coverage under MAP portion of **plan**.
If you are pregnant	Office visits	Not covered	See MAP Description for coverage under MAP portion of **plan**.
	Childbirth/delivery professional services	Not covered	
	Childbirth/delivery facility services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	
	Rehabilitation services	Not covered	
	Habilitation services	Not covered	
	Skilled nursing care	Not covered	
	Durable medical equipment	Not covered	
	Hospice services	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	
	Children's glasses	95% coinsurance	Covered up to age 19.
	Children's dental check-up	Not covered	See MAP Description for coverage under MAP portion of **plan**.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Diagnostic test (x-ray, blood work) & Imaging (CT/PET scans, MRIs)
- Emergency room care/Urgent care
- Home health care
- Infertility treatment
- Long-term care
- Outpatient surgery facility/physician/surgeon fees
- Prenatal care/childbirth/delivery facility/professional services
- Primary care/specialist office visit
- Rehabilitation/habilitation services/Chiropractic care
- 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.)
•The only services covered under the Wrap-Around Major Medical portion of the **plan** are listed in the Common Medical Event section of this document.

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 the University Benefits Office at 585-275-2084.
- 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:

- The University of Rochester Benefits Office at 585-275-2084.
- 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 available from the University of Rochester Benefits Office 585-275-2084.

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? No.
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 **585-275-2084.**

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** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,400
The total Joe would pay is	**$7,400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) copayment** **$0**
- **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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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