University of Rochester : YOUR PPO Plan

Coverage for: Employee + Family | **Plan Type:** POS

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/totalrewards** or by calling **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 **585-275-2084** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Accountable Health Partners (AHP): Employee (EE) Only $500; EE+ Family (FAM) $1,250. In Network: EE Only $1,250; EE+ FAM $3,125. Out–of–Network (OON): EE Only $3,000; EE+ FAM $9,000.	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. In-network office visits & preventive care are 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	*Salary<$62,100; AHP: EE Only $2,000; FAM $4,000. In Network: EE Only $3,000; FAM $5,500. OON: EE Only $5,000; FAM $10,000. Salary > $62,100; AHP: EE Only $2,750; FAM $5,500. In Network: EE Only $4,250; FAM $8,500 OON: EE Only $6,500; FAM $13,000.	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. *NOTE: the <$62,100 salary band includes residents and fellows and the >$62,100 includes all part-time (PT) employees.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	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?	Yes. See ahpnetwork.com (AHP), excellusbcbs.com (Excellus) or call (585)758-7823 (AHP), 1-800-659-2808 (Excellus) for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit, deductible doesn't apply	$35 copay/visit, deductible doesn't apply	40% coinsurance	None
	Specialist visit	$35 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	40% coinsurance	None
	Preventive care / screening / immunization	No charge	No charge	Not covered	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)	10% coinsurance	25% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcbs.com	Generic drugs	Not applicable	Copay/prescription, deductible doesn't apply: $15 (retail), $37.50 (mail order)	Not covered	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.
	Preferred brand drugs	Not applicable	20% coinsurance with minimum (min) & maximum (max)/prescription, deductible doesn't apply: $25 min & $60 max (retail), $62.50 min & $150 max (mail order)	Not covered	

* For more information about limitations and exceptions, see the plan document at www.rochester.edu/totalrewards.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition (continued)	Non-preferred brand drugs	Not applicable	35% coinsurance with min & max/prescription, deductible doesn't apply: $50 min & $120 max (retail), $125 min & $300 max (mail order)	Not covered	
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs	Not covered	Limit one retail supply at a network pharmacy. All other fills must be made at a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance ambulatory surgery center; 25% coinsurance all other facilities	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	10% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	25% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	40% coinsurance	Penalties apply for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay/visit, deductible doesn't apply; Other outpatient services: 10% coinsurance	Office: $20 copay/visit, deductible doesn't apply; Other outpatient services: 10% coinsurance	Office & other outpatient services: 40% coinsurance	Outpatient services provided by Behavioral Health Partners (BHP) covered at 100% (no deductible or copay)
	Inpatient services	10% coinsurance	10% coinsurance	40% coinsurance	Penalties apply for failure to obtain pre-authorization for out-of-network care.

* For more information about limitations and exceptions, see the plan document at www.rochester.edu/totalrewards.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Accountable Health Partners Provider	In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal/Postnatal Office visits	No charge	No charge	40% coinsurance	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalties may apply for failure to obtain pre-authorization for out-of-network care.
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	40% coinsurance	Penalties apply for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$35 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	40% coinsurance	45 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Age and frequency limits may apply to Habilitation services.
	Habilitation services	$35 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	40% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	40% coinsurance	120 days/calendar year. Penalties apply for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	10% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	25% coinsurance	40% coinsurance	Penalties apply for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan document at www.rochester.edu/totalrewards.

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)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs (other than services through lifestyle and condition management programs)

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

- Acupuncture - 10 visits/calendar year.
- Bariatric surgery
- Chiropractic care
- Hearing aids - $600 maximum/3 years per child up to age 19.
- Infertility treatment - For more information about limitations & exceptions, see plan document.
- Non-emergency care when traveling outside the U.S.

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: Excellus 1-800-499-1275. You may also contact
- your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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: Excellus 1-800-499-1275 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: excellusbcbs.com/UR (Excellus)

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Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 Excellus at 1-800-499- 1275.

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (585) 275-4778.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (585) 275-4778.]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (585) 275-4778.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (585) 275-4778.]

----------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	$500
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$80
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,840**

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

The plan's overall deductible	$500
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$500
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$780**

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.