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, visit www.rochester.edu/totalrewards 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 You can view the Glossary at www.cciio.cms.gov or 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?	Accountable Health Partners (AHP): $500/Employee (EE) Only or $1,250/EE + Family (FAM) For in network providers: $1,250/ EE Only or $3,125/ FAM For out-of-network providers: $3,000/ EE Only or $9,000/ FAM	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 preventive care and primary care services 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 < $64,000: AHP: $2,000/EE Only or $4,000/FAM; in network providers: $3,000/ EE Only or $5,500/ FAM; out-of-network providers: $5,000/ EE Only or $10,000/ FAM *Salary > $64,000: AHP: $2,750/EE Only or $5,500/FAM; in network providers: $4,250/ EE	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.

Important Questions	Answers	Why This Matters:
	Only or $8,500/ FAM; out-of-network providers: $6,500/ EE Only or $13,000/ FAM	
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for certain services, premiums, balance-billing charges, and 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?	Yes. See www.ahpnetwork.com or www.excellusbcbs.com or call 1-585-758-7823 (AHP) or 1-800-659-2808 (Excellus) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You pay the least if you use a provider in the AHP network. You pay more if you use an in-network provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). 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 (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit; deductible does not apply	$35 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$35 copay/office visit; deductible does not apply	$65 copay/office visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	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	Imaging services: Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance	40% coinsurance	
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 covered	$15 copay/prescription (retail order) ; deductible does not apply $37.50 copay/prescription (mail order) ; deductible does not apply	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives; deductible does not apply. Certain prescription drugs require preauthorization. If you don't get preauthorization, your prescription drug will not be covered. Review your formulary for prescriptions requiring preauthorization or step therapy.
	Preferred brand drugs	Not covered	20% coinsurance with minimum (min) & maximum (max)/prescription; deductible does not	Not covered	

* For more information about limitations and exceptions, see the plan or policy 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 (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
			apply $25 min & $60 max (retail), $62.50 min & $150 max (mail order)		The plan requires pharmacies to dispense generic drugs, when available. If you or your provider chooses a higher cost drug instead of the generic equivalent, you will be required to pay the applicable cost-sharing for the higher cost drug, plus the cost-difference between the generic drug and the higher cost drug. This cost difference will not apply to your out-of-pocket limit. All specialty drugs must be obtained from a Designated Pharmacy. Coverage will not be provided for specialty drugs obtained at any other pharmacy. More information about specialty drug coverage is available at: www.excellusbcbs.com. For certain specialty drugs, you must confirm enrollment in the SaveonSP program by calling 1-800-683-1074. Specialty drugs available through the SaveonSP program are considered non-essential; therefore, if you fail to confirm your enrollment in the SaveonSP program, any cost-sharing you pay for specialty drugs available through such program will not count toward your out-of-pocket limit.
	Non-preferred brand drugs	Not covered	35% coinsurance; deductible does not apply $50 min & $120 max (retail), $125 min & $300 max (mail order)	Not covered	
	Specialty drugs (Tier 4)	Not covered	Applicable cost as noted above for generic or brand drugs	Not covered	
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	Emergency room	10% coinsurance	10% coinsurance	10% coinsurance	Emergency room care: No coverage for non-

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Accountable Health Partners Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
medical attention	care				emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	25% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network providers. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit, deductible does not apply, and 10% coinsurance for other outpatient services	$20 copay/office visit, deductible does not apply, and 10% coinsurance for other outpatient services	40% coinsurance	Outpatient services provided by Behavioral Health Partners (BHP) covered at no charge; deductible does not apply.
	Inpatient services	10% coinsurance	10% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge; deductible does not apply	No charge; deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network providers. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
If you need help recovering or have	Home health care	10% coinsurance	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network providers. If you don't get preauthorization, benefits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Accountable Health Partners Provider (You will pay the least)	Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
other special health needs					could be reduced by 50% of the total cost of the service or $500, whichever is less.
	Rehabilitation services	$35 copay/visit; deductible does not apply	$65 copay/visit; deductible does not apply	40% coinsurance	45 visits/year. Includes physical therapy, speech therapy, and occupational therapy combined, including outpatient hospital services. Age and frequency limits may apply to habilitation services.
	Habilitation services	$35 copay/visit; deductible does not apply	$65 copay/visit; deductible does not apply	40% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	40% coinsurance	120 visits/calendar year. Preauthorization is required for out-of-network providers. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
	Durable medical equipment	10% coinsurance	10% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, repairs for misuse/abuse, exercise, and bathroom equipment. Preauthorization is required for durable medical equipment greater than $200. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
	Hospice services	10% coinsurance	25% coinsurance	40% coinsurance	Preauthorization is required for out-of-network providers. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or $500, whichever is less.
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

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 documents
- 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: Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov.ebsa/healthreform. 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 on how 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 Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, http://www.communityhealthadvocates.org/ (website), cha@cssny.org (email). A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gove/CCIIO/Resources/Consumer-Assistance-Grants/.

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 the Minimum Value Standards? 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-499-1275.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-499-1275.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-499-1275.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-499-1275.

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

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

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	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,770**

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	$500
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,160**

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	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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