



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](http://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 [www.cciio.cms.gov](http://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:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Accountable Health Partners (AHP): \$500/Employee (EE) Only or \$1,250/EE + Family (FAM)</p> <p>For <a href="#">in network providers</a>: \$1,250/EE Only or \$3,125/ FAM</p> <p>For <a href="#">out-of-network providers</a>: \$3,000/ EE Only or \$9,000/ FAM</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. In network <a href="#">preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>*Salary &lt; \$64,900: AHP: \$2,000/EE Only or \$4,000/FAM; <a href="#">in network providers</a>: \$3,000/ EE Only or \$5,500/ FAM; <a href="#">out-of-network providers</a>: \$5,000/ EE Only or \$10,000/ FAM</p> <p>*Salary &gt; \$64,900: AHP: \$2,750/EE Only or \$5,500/FAM; <a href="#">in network providers</a>: \$4,250/ EE</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>

Important Questions	Answers	Why This Matters:
	Only or \$8,500/ FAM; <a href="#">out-of-network providers</a> : \$6,500/ EE Only or \$13,000/ FAM	
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">preauthorization</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.ahpnetwork.com">www.ahpnetwork.com</a> or <a href="http://www.excellusbcbcs.com">www.excellusbcbcs.com</a> or call 1-888-457-7463 (AHP) or 1-800-659- 2808 (Excellus) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You pay the least if you use a <a href="#">provider</a> in the AHP network. You pay more if you use an <a href="#">in-network provider</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	\$35 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	\$65 <a href="#">copay</a> /office visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Imaging services: <a href="#">Preauthorization</a> is required (Does not apply to AHP Network). If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a>	Generic drugs	Not covered	\$15 <a href="#">copay</a> /prescription (retail order) ; <a href="#">deductible</a> does not apply \$37.50 <a href="#">copay</a> /prescription (mail order) ; <a href="#">deductible</a> 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; <a href="#">deductible</a> does not apply.  Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , your <a href="#">prescription drug</a> will not be covered. Review your formulary for prescriptions requiring <a href="#">preauthorization</a> or step therapy.
	Preferred brand drugs	Not covered	20% <a href="#">coinsurance</a> with minimum (min) & maximum (max)/prescription; <a href="#">deductible</a> does not	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.rochester.edu/totalrewards](http://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)		<p>The <a href="#">plan</a> 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 <a href="#">cost-sharing</a> 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 <a href="#">out-of-pocket limit</a>.</p> <p>All <a href="#">specialty drugs</a> must be obtained from a Designated Pharmacy. Coverage will not be provided for <a href="#">specialty drugs</a> obtained at any other pharmacy. More information about <a href="#">specialty drug</a> coverage is available at: <a href="http://www.excellusbcbcs.com">www.excellusbcbcs.com</a>.</p> <p>For certain <a href="#">specialty drugs</a>, you must confirm enrollment in the SaveonSP program by calling 1-800-683-1074. <a href="#">Specialty drugs</a> available through the SaveonSP program are considered non-essential; therefore, if you fail to confirm your enrollment in the SaveonSP program, any <a href="#">cost-sharing</a> you pay for <a href="#">specialty drugs</a> available through such program will not count toward your <a href="#">out-of-pocket limit</a>.</p>
	Non-preferred brand drugs	Not covered	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply \$50 min & \$120 max (retail), \$125 min & \$300 max (mail order)	Not covered	
	<a href="#">Specialty drugs</a> (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% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> : ambulatory surgery center; 25% <a href="#">coinsurance</a> : all other facilities	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate	<a href="#">Emergency room</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Emergency room care</a> : No coverage for non-

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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	<a href="#">care</a>				emergency use.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for <a href="#">out-of-network providers</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply, and 10% <a href="#">coinsurance</a> for other outpatient services	\$20 <a href="#">copay</a> /office visit, <a href="#">deductible</a> does not apply, and 10% <a href="#">coinsurance</a> for other outpatient services	40% <a href="#">coinsurance</a>	Outpatient services provided by Behavioral Health Partners (BHP) covered at no charge; <a href="#">deductible</a> does not apply.
	Inpatient services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).  <a href="#">Preauthorization</a> is required for <a href="#">out-of-network providers</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for <a href="#">out-of-network providers</a> . If you don't get <a href="#">preauthorization</a> , benefits

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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)	
<b>other special health needs</b>					could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$65 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	45 visits/year. Includes physical therapy, speech therapy, and occupational therapy combined, including outpatient hospital services. Age and frequency limits may apply to <a href="#">habilitation services</a> .
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$65 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	120 visits/calendar year. <a href="#">Preauthorization</a> is required for <a href="#">out-of-network providers</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, repairs for misuse/abuse, exercise, and bathroom equipment. <a href="#">Preauthorization</a> is required for <a href="#">durable medical equipment</a> greater than \$200 (Does not apply to AHP Network). If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for <a href="#">out-of-network providers</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of the total cost of the service or \$500, whichever is less.
<b>If your child needs dental or eye care</b>	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](#) or policy document at [www.rochester.edu/totalrewards](http://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 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](http://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](http://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](http://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](mailto:cha@cssny.org) (email). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/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, kwijigo holne' 1-800-499-1275.

*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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,770</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,160</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1000</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.